Section II - Helping Survivors

The task of helping survivors is a difficult one in which, often, any action seems too little given the magnitude of the disaster and its consequences. Nonetheless, disaster mental health workers make significant contributions to the recovery of survivors.

Helping interventions are best understood in the context of when, where, and with whom interventions take place. For example, emergency (when) on-site (where) interventions with ambulatory survivors (whom) will have as their primary objective the providing of a safe and secure base from which survivors can regain (within reason) a degree of equilibrium; three weeks following the disaster, interventions provided in community settings are apt to be educational and exploratory with the objective of increasing awareness of the biopsychosocial impact of the event and ways to maximize adults' and children's coping; six months later, interventions provided in clinical settings may include formal assessment and treatment protocols for persistent symptoms related to post-traumatic stress. The follow sections, helping survivors, helping the helpers, and helping organizations provide guidelines for various types of intervention.

"**When**" is delineated by three temporal phases:

Emergency phase: the immediate period after disaster strikes;

Early post-impact phase: approximately anytime from the day after the onset of the disaster until the eighth to twelfth week;

Restoration phase: marked by the implementation of long-term recovery programs, generally beginning about the eighth to twelfth week after the onset of the disaster.

"**Where**" is delineated by site:

On-site: (ground zero) where destruction and devastation has just occurred;

Off-site: where survivors congregate

"**Whom**" is delineated by an individual's age, role or function:

Child survivors

Adult survivors

Older adult survivors

Helpers

Communities

Organizations

Emergency Phase On- and Off-site Interventions

"Off-site" Settings

- Shelters and Meal Sites
- Red Cross Service Centers
- Medical Examiner's Office
- Emergency Operations Center (EOC)
- Fire and Police Departments
- Disaster Applications Centers (DAC)
- Hospitals and First Aid Stations
- Coroner's Office
- Schools and Neighborhood Community Centers

At the site(s) of impact and in disaster services areas, the first mental health services are provided on an improvised basis by voluntary bystanders who may or may not have professional training or skills. When mental health professionals are deployed to a disaster by an agency, they rarely are the first responders. Thus, even if a mental health professional enters the disaster site only a few minutes or hours after impact, her or his first responsibility is to identify these "natural helpers," join with them in providing crisis care, and rapidly but sensitively relieve them of these responsibilities. Helping bystander crisis responders to get to a safe and appropriate place outside the impact area is a delicate and important first step in caring for disaster survivors. The closest Emergency Command Center begins coordinating communication and, if necessary, an Incident Command (IC) center is set up near the periphery of sites to direct emergency operations.

Generally, mental health workers are apt to be located at "off-site" settings where survivors congregate.

Photo by Donna Hastings

Photo by Donna Hastings

Protect, Direct, Connect Triage, Acute Care, Death notification

Whether on-site or off-site, initial mental health interventions are primarily pragmatic.

- **Protect**[1]**:** Find ways to protect survivors from further harm and from further exposure to traumatic stimuli. If possible:

  Create a "shelter" or safe haven for them, even if it is symbolic. The less traumatic stimuli people see, hear, smell, taste, feel, the better off they will be.

  Protect survivors from onlookers and the media.

- **Direct:** Kind and firm direction is needed and appreciated. Survivors may be stunned, in shock, or experiencing some degree of dissociation. When possible, direct ambulatory survivors:

  Away from the site of destruction

  Away from severely injured survivors

  Away from continuing danger

- **Connect:** The survivors you encounter at the scene have just lost connection to the world that was familiar to them. A supportive, compassionate, and nonjudgmental verbal or nonverbal exchange between you and survivors may help to give the experience of connection to the shared societal values of altruism and goodness. However brief the exchange, or however temporary its effects, in sum such "relationships" are important elements of the recovery or adjustment process. Help survivors connect:

  To loved ones

  To accurate information and appropriate resources

  To where they will be able to receive additional support

[1] The construct "Protect, Direct, Connect" was developed by Diane Myers, unpublished manuscript.

- **Triage:** The majority of survivors experience normal stress reactions. However, some may require immediate crisis intervention to help manage intense feelings of panic or grief. Signs of panic are trembling, agitation, rambling speech, erratic behavior. Signs of intense grief may be loud wailing, rage, or catatonia. In such cases, attempt to quickly establish therapeutic rapport, ensure the survivor's safety, acknowledge and validate the survivor's experience, and offer empathy. Medication may be appropriate and necessary, if available.

- **Acute Care:** Those survivors who require immediate crisis intervention to help manage intense feelings of panic or grief can be helped by your presence. When possible, stay with the survivor in acute distress or find someone else to remain with him/her until the feelings subside. If possible, consult a physician or nurse regarding utility of medication. Ensure the survivor's safety, and acknowledge and validate the survivor's experience.

- **Death Notification:** Mental health personnel may be asked to serve on coroners' or medical examiners' death notification teams (Sitterle, 1995). Mothers Against Drunk Driving (MADD) developed a curriculum on compassionate death notification for professional counselors and victim advocates (Lord, 1996), which is summarized and printed with the permission of MADD.

Death Notification Procedure

1. The coroner or medical examiner is absolutely responsible for determining the identity of the deceased.

2. Notify in person. Don't call. Do not take any possessions of the victim to the notification. If there is absolutely no alternative to a phone call, arrange for a professional, neighbor, or a friend to be with the next of kin when the call comes.

3. Take someone with you (for example, an official who was at the scene, clergy, and someone who is experienced in dealing with shock and / or trained in CPR / medical emergency). Next of kin have been known to suffer heart attacks when notified. If a large group is to be notified, have a large team of notifiers.

4. Talk about your reactions to the death with your team member(s) before the notification to enable you to better focus on the family when you arrive.

5. Present credentials and ask to come in.

6. Sit down, ask them to sit down, and be sure you have the nearest next of kin (do not notify siblings before notifying parents or spouse). Never notify a child. Never use a child as a translator.

7. Use the victim's name... "Are you the parents of _____?"

8. Inform simply and directly with warmth and compassion.

9. Do not use expressions like "expired," "passed away," or "we've lost _____."

10. Sample script: "I'm afraid I have some very bad news for you." Pause a moment to allow them to "prepare." "*Name* has been involved in _____ and (s)he has died." Pause again. "I am so sorry." Adding your condolence is very important because it expresses feelings rather than facts, and invites them to express their own.

11. Continue to use the words "dead" or "died" through ongoing conversation. Continue to use the victim's name, not "body" or "the deceased."

12. Do not blame the victim in any way for what happened, even though he / she may have been fully or partially at fault.

13. Do not discount feelings, theirs or yours. Intense reactions are normal. Expect fight, flight, freezing, or other forms of

regression. If someone goes into shock have them lie down, elevate their feet, keep them warm, monitor breathing and pulse, and call for medical assistance.

14. Join the survivors in their grief without being overwhelmed by it. Do not use cliches. Helpful remarks are simple, direct, validate, normalize, assure, empower, express concern. *Examples:* "I am so sorry." "It's harder than people think." "Most people who have gone through this react similarly to what you are experiencing." "If I were in your situation, I'd feel very _____ too."

15. Answer all questions honestly (requires knowing the facts before you go). Do not give more detail than is asked for, but be honest in your answers.

16. Offer to make calls, arrange for child care, call clergy, relatives, employer. Provide them with a list of the calls you make as they will have difficulty remembering what you have told them.

17. When a child is killed and one parent is at home, notify that parent, then offer to take them to notify the other parent.

18. Do not speak to the media without the family's permission.

19. If identification of the body is necessary, transport next of kin to and from morgue and help prepare them by giving a physical description of the morgue, and telling them that "*Name*" will look pale because blood settles to point of lowest gravity.

20. Do not leave survivors alone. Arrange for someone to come and wait until they arrive before leaving.

21. When leaving let him / her or them know you will check back the next day to see how they are doing and if there is anything else you can do for them.

22. Call and visit again the next day. If the family does not want you to come, spend sometime on the phone and re-express willingness to answer all questions. They will probably have more questions than when they were first notified.

23. Ask the family if they are ready to receive "*Name's*" clothing, jewelry, etc. Honor their wishes. Possessions should be presented neatly in a box and not in a trash bag. Clothing should be dried thoroughly to eliminate bad odor. When the family

receives the items, explain what the box contains and the condition of the items so they will know what to expect when they decide to open it.

24. If there is anything positive to say about the last moments, share them now. Give assurances such as "most people who are severely injured do not remember the direct assault and do not feel pain for some time." Do not say, "s(he) did not know what hit them" unless you are absolutely sure.

25. Let the survivor(s) know you care. The most beloved professionals and other first responders are those who are willing to share the pain of the loss. Attend the funeral if possible. This will mean a great deal to the family and reinforces a positive image of your profession.

26. Know exactly how to access immediate medical or mental health care should family members experience a crisis reaction that is beyond your response capability.

27. Debrief your own personal reactions with caring and qualified disaster mental health personnel on a frequent and regular basis - don't try to carry the emotional pain all by yourself, and don't let your emotions and the stress you naturally experience in empathizing with the bereaved build into a problem for you.

Summary of Basic Principles of Emergency Care

It is helpful to remember and be guided by several "basic principles" or objectives of emergency care.

1. Provide for basic survival needs and comfort (e.g., liquids, food, shelter, clothing, heat / cooling).
2. Help survivors achieve restful and restorative sleep.
3. Preserve an interpersonal safety zone protecting basic personal space (e.g., privacy, quiet, personal effects).
4. Provide nonintrusive ordinary social contact (e.g., a "sounding board," judicious uses of humor, small talk about current events, silent companionship).
5. Address immediate physical health problems or exacerbations of prior illnesses.
6. Assist in locating and verifying the personal safety of separated loved ones / friends.
7. Reconnect survivors with loved ones, friends, trusted other persons (e.g., AA sponsors, work mentors).
8. Help survivors take practical steps to resume ordinary day-to-day life (e.g., daily routines or rituals).
9. Help survivors take practical steps to resolve pressing immediate problems caused by the disaster (e.g., loss of a functional vehicle, inability to get relief vouchers).
10. Facilitate resumption of normal family, community, school, and work roles.
11. Provide opportunities for grieving for losses.
12. Help survivors reduce problematic tension, anxiety or despondency to manageable levels.
13. Support survivors' indigenous helpers through consultation and training about common stress reactions and stress management techniques.

EARLY POST-IMPACT PHASE

The early post-impact phase can be described as the period when "first on-the scene" responders are replaced by officially designated responders and informal and formal crisis interventions transition to disaster response plans. The onset of this phase generally occurs 24-48 hours after the Presidential declaration of disaster and may last until the federally-funded crisis counseling programs are in place (an average of 14 weeks after the declaration).

Within days after the Presidential declaration of disaster, the Federal Emergency Management Agency (FEMA) establishes a Disaster Field Office (DFO). FEMA is responsible for coordinating emergency activities provided by federal, state, and county governments. The overall coordination of disaster mental health services takes place in the DFO with representatives from Public Health Service, Center for Mental Health Services, American Red Cross, and the state's department of mental health. Generally, the state's department of mental health and American Red Cross officials work with community mental health authorities to further coordinate services.

Within days after the onset of the disaster, the focus of disaster mental health shifts from crisis assistance to facilitating psychological and interpersonal stabilization among survivors and disaster workers. During the transition from impromptu mental health care to coordinated care, volunteer bystanders and first responders who are mental health professionals may be reluctant to relinquish their response role to authorized disaster mental health officials. Their reluctance may be understood in context, that is, these volunteers will have, to varying degrees, sustained an emotional shock that may make it difficult to maintain their standard professional mental health roles and boundaries. Conflict may occur, requiring understanding, tact, and firmness by those who must assume responsibility.

During the early post-impact phase, private sector and professional organizations may send volunteers to provide mental health assistance. In some cases, this can hamper mental health care coordination among administrators and create confusion among those receiving services. Over the last several years, American Red Cross (ARC) has undertaken to develop "Statements of Understanding" with professional organizations (e.g., American Psychiatric Association, American Psychological Association, National Association of Social Workers, National Association of Marriage and Family Counselors) with the aim of enhancing recruitment and deployment of mental health volunteers through official channels (i.e., federal, state, and ARC coordinators).

General Interventions

During the early-post impact phase, the pragmatic "Protect, Direct, Connect, Triage" activities are supplemented to include general psychoeducational interventions:

- Provide user-friendly educational materials and presentations (e.g., choose material with plain language, preferably not above the 5th grade reading level).
- Provide defusings, debriefings and stress-management education.
- Help survivors cope with "normal" stress reactions by providing unobtrusive practical and emotional support. Emotional support in crises reduces helplessness and enhances recovery.
- Continue to identify individuals and families at-risk for longer-term psychological problems.

Years after disaster, 25-33% of survivors have chronic or delayed onset PTSD/ PTPI, often in the form of recurrent intrusive re-experiencing. Given these rates of chronic trauma-related impairment, disaster mental health workers must take steps to assist indigenous healthcare, social service, and advocacy personnel in ongoing identification of survivors at high-risk for sustained mental health problems.

Baum & Fleming (1993); Baum, Cohen & Hall (1993); Green et al. (1990a, 1992); Joseph et al. (1995); Lima et al. (1993).

Guidelines For Working In Settings Where Many Survivors Are Congregated: <u>The One-To-One Intervention</u>

Though settings vary, disaster mental health workers often find themselves "working" a room full of survivors numbering in the hundreds. In a brief period of time, clinicians must establish a "relationship" with setting manager's, set priorities, assess the environment, survivors and workers, conduct interventions, and obtain "closure."

Establish "Relationship" With Setting Manager/Administrator/ Workers

• Introduction

Introduce yourself and briefly explain the purpose of your visit / assignment and how long you will be at the particular site. In many cases, experienced site managers will be expecting mental health support. Sometimes, however, the person in charge will be too busy to speak with you. If your DMH supervisor has previously made contact with the setting supervisor, or you and / or your team are one of a succession of mental health teams assigned to the site, simply checking in with other key staff at the site can be sufficient.

• Inquiry of Needs

Ask the manager if he or she has particular concerns about the setting (e.g., noise, crowding, need of special designated areas) or concerns about a specific family, individual, or worker. If timing is appropriate, ask the manager how he or she is "holding up."

• Expectations of Mental Health Services

Inquire about the manager's understanding of your role. If necessary, "correct" unrealistic expectations. For example, an inexperienced manager may believe you are there to evaluate fitness for duty, or that you represent the "mental health police." It may be helpful to underscore that your mission is to provide *support* for victims and staff and that you are not there to do job performance evaluations. It may be useful to inquire if there have been previous site visits by other mental health staff and whether it was helpful to have a mental health team at the site.

Observe Setting

Evaluate environment, e.g., noise level, crowding, seating arrangements, availability of water, presence of designated children's area, quiet area, use of bulletin boards, availability of printed information, exposure to traumatic stimuli via television programming. Make appropriate recommendations. It is not uncommon for the new DMH clinician to quickly become engaged with the first "problem" encountered. Most likely, adrenaline levels are high and it is compelling to respond to the immediacy of any one person's problem. However, by first taking an observer's position, priorities can be set and the importance of environmental variables and the scope of the mental health services required can be appreciated.

Arrange And Make Contact With Survivors

The most natural form of contact with survivors in a large setting occurs when disaster mental health clinicians volunteer to be in positions that involve some form of practical help, e.g., serving food, bringing drinks to people in line, or passing out blankets. If possible, make arrangements to attend a staff meeting to inform site workers about how you might be able to assist them with a survivor or family who could benefit from stress management services. Time spent mingling in a staff break area can include inquiries about survivors who may require mental health services.

Defusing: A 6-Step Guide[2]

"Defusing" is a term that has been used to describe the process of helping through the use of brief conversation. Because post-disaster settings where survivors congregate are often chaotic, the majority of defusings are short. A defusing may take place in passing, in a line for services, while eating, etc. Broadly speaking, defusings are designed to give survivors an opportunity to receive support, reassurance, and information. In addition, defusing provides the clinician with an opportunity to assess and refer individuals who may benefit from more in depth social or mental health service. More specifically, defusing may help the survivor shift from survival mode to focusing on practical steps to achieve restabilization. It may also help survivors to better understand the many thoughts and feelings associated with their experience. Defusings can take place continuously as the clinician "works" the room. As previously mentioned, finding unobtrusive ways to be in the vicinity of survivors will facilitate the defusing process. We recommend using the following 6-step guide:

1. Make contact

Begin defusing with informal socializing, e.g., "*Can I get you a juice or soft drink?" " Have you been waiting long?"* Avoid statements that might appear to be condescending or trivializing, e.g., "*How are you feeling?" "Everyone here is lucky to be alive."* Do not begin by asking for a detailed account of the survivor's disaster experience.

2. Make assessment

Assess the individual's ability and willingness to shift from a current focus and purpose (seeking or receiving relief assistance) to "social" conversation. If the person appears preoccupied with practical concerns and is unable to make a shift, ask open-ended questions related to their concerns, e.g., *"How can we help you while you're waiting for information"* or provide offers of help that are within your power to fulfill, e.g., *"I don't know if your neighborhood remains cordoned off, but I'd be glad to see if anyone has an update."* Follow the "flow" of the individual's thoughts. During the course of the conversation, evaluate how the person responds to an inquiry about where they were, or who they were with when the disaster struck.

3. Gather facts

The gathering of facts is important because it is an efficient means to quickly determine who may be at risk due to exposure to life threat, grotesque experiences, or other traumatic stimuli.

[2] Developed by Bruce H. Young and Julian D. Ford. Based on the 4-Step Guide, developed by Diane Myers and Len Zunin (Unpublished manuscript).

Describing facts is also easier for survivors than relating associated thoughts or feelings.

Helpful Questions:

- "Where were you when it happened?"
- "What did you do first, then what did you do?"
- "What do you remember seeing, smelling, and hearing?"
- "Where is your family?"
- "Where were other people?"
- "Is there anything anyone said to you that stands out in your memory?"
- How has this experience affected your marriage, your work, your sleep, your appetite, etc.?"

4. Inquire about thoughts

Use the description of facts that the survivor has provided to generate questions about associated thoughts.

Helpful Questions:

- "When hearing about the approaching disaster, what did you first think?"
- "What were your first thoughts when the disaster struck?"
- "What ran through your mind when you first awoke to the loud noise of the _____?"
- "What ran through your mind during the course of the evacuation?"
- "What are your thoughts now that the immediate threat is over?"
- "What thoughts will you carry with you?"
- "Is there any particular thing you keep thinking about over and over again?"

5. Inquire about feelings

Use the description of thoughts that survivors have provided to ask questions about their emotional experiences. Remember, defusing is a brief intervention and it precludes in depth exploration and ongoing support. Consequently you must use care in regard to any questions about feelings. It is important to avoid heightening a survivor's sense of vulnerability to the degree that it causes overwhelming anxiety. Obviously, under such time constraints, assessing capacity to manage anxiety is difficult, so it is best to proceed conservatively, i.e., continually monitor the survivor's reactions during the course of talking about their feelings and reassess the need to refocus the survivor's attention on the

present and action-oriented steps to solve problems (caveats are addressed below). If the survivor is able to tolerate talking about feelings, look for opportunities to validate common emotional reactions and concerns. "De-pathologize" survivors' reactions, that is, inform them about normal reactions to the "abnormal" event to provide reassurance. Helping survivors to understand the common course of traumatic reactions, while giving them an opportunity to discuss trauma-related thoughts and feelings will not bring closure to their experience. However, it may serve to give the survivor a greater sense of control and prevent the adverse effects of emotional numbing or dissociation.

Helpful Questions:

- "What was the most difficult or hardest thing about the event for you?"
- "How have you been feeling since _____ happened?"
- "How are you feeling now?"

6. Support, reassure, provide information

Though listed as the last of the six steps, offering support, reassurance, and providing information should actually take place throughout the defusing. Providing support via reflective listening, giving information, and offering practical help may help the survivor cope with the psychological isolation that often accompanies a traumatic experience. Reassurance about normal reactions to the event may mitigate self-criticism and worry. Information about common stress reactions in adults, children, elders, and stress management strategies, may also mitigate anxiety and worry, and help survivors copy with feelings of helplessness or loss of control.

As you move toward closure of the defusing, it is important to assess the survivor's support system to enable you to determine if a referral to support services is necessary. It is also important to underscore the value that social support can have in the recovery process. Helping survivors recall previously successful coping strategies may also be useful. It is helpful to have a one page handout listing post-disaster community resources including mental health and social services.

Helpful Questions:

- "What has helped you to cope with this experience?"
- Who, if anyone, do you talk to?"
- What seems to help you get through the particularly difficult periods?"

- ”What has helped before when you have experienced tremendous stress?”

Caveats

In the course of most defusings, survivors are able to disclose and reflect upon recollections, thoughts, and feelings with some distress, but with a gradual increasing sense of understanding and relief. However, for a small number of individuals, the recollection or disclosure of disaster experiences may precipitate intense emotional distress, cognitive confusion, and/or behavioral disinhibition (e.g., angry outbursts, suicidal ideation, panic attacks). These adverse reactions are not necessarily “caused by” defusing; their occurrence may be imminent even if they are, in part, reactions to the defusing experience. Defusing thus offers a potentially important opportunity to screen for at-risk individuals who might otherwise have undetected adverse stress reactions or deteriorating pre-existing mental health problems. Several steps should be taken to clinically manage these rare but serious incidents, and to ensure the safety and well being of every participant:

- If possible, obtain a pre-defusing assessment with key spokespersons or leaders who are well-informed about participants’ past and current mental state and possible vulnerabilities. Such assessment typically is done informally but with a clear statement that information provided or obtained will be held in strict confidence (barring any legally-mandated duty-to-warn), and will be used to determine the best approach to including participants who are at risk for adverse reactions in the defusing or for providing them with alternative services. The assessment should include inquiries about:

  (a) extreme peritraumatic stress or dissociative reactions;

  (b) pre-existing psychopathology (e.g., mood or anxiety disorders; thought disorders; bipolar illness; substance abuse disorders);

  (c) prior traumatization (e.g., community or domestic violence, disasters).

- Pay close attention to potential risk factors when talking with an individual. When you identify an individual who is having more than temporary moderate difficulty in coping (e.g., persistent severe fear or sleep problems; dangerously impulsive risk taking behavior; difficulty controlling temper without yelling or becoming physically aggressive), find a private place to talk. Utilize basic crisis intervention principles to help the person resume basic safety, daily living, and stress coping activities.

1. Determine if emergency medical/psychiatric care is necessary, and if so, get assistance and arrange transportation to secure urgent care site.
2. Identify one or two practical problems that are most troubling to the individual and that would provide significant relief if even partially resolved. Brainstorm solutions, develop a realistic action plan, and help the individual take and evaluate the first few steps in the action plan.
3. Identify sources of social support and assist the person in making positive contacts with those individuals or groups.
4. Assist the individual in making contact with indigenous providers or ongoing mental health and social services. Make a phone call or accompany the individual to meet appropriate providers if there is uncertainty about the person's ability to follow through with the referral (e.g., due to cognitive deficits or emotional liability).

Termination at site

Inform site manager or other key site personnel that you will be leaving. When appropriate, summarize activities and discuss recommendations you may have.

Debriefing

When time and circumstances permit, mental health responders can offer more systematic, structured attempts to help survivors make sense of their experiences, and possibly, prevent development of longer-term problems. The chief structured preventive intervention in current practice is "debriefing."

Originally developed by Jeffrey Mitchell (1983) to mitigate the stress among emergency first responders, *critical incident stress debriefing (CISD)* is now a widely-used protocol with survivors and providers of disaster-related services (e.g., teachers, clergy, administrative personnel) in a wide range of settings (e.g., schools, churches, community centers). Mitchell's expanded critical incident stress management model was developed to address the need for more extensive interventions than can be provided in debriefing alone. Related models are being developed by other disaster and emergency mental health teams (e.g., Armstrong, O'Callahan & Marmar, 1991; and the model described herein).

Debriefing has become a generic term applied to a structured process that helps survivors understand and manage intense emotions, identify effective coping strategies, and receive support from peers. Regardless of the brand name and specific technical steps recommended, the key guideline is to use debriefing as a component in an integrated approach to providing survivors and workers with appropriate education, peer support, and opportunities to consciously translate affectively-laden memories into a coherent and self-enhancing narrative understanding of these disaster experiences.

Debriefing is unlikely to be effective as the sole intervention for complex, ongoing, or persistent problems that are the result of pre-existing stress. The lifetime and current prevalence rates of PTSD (9%) and adult psychiatric disorder (48%) suggest that many disaster survivors need to address trauma reactivation or pre-existing mental disorders (Hiley-Young & Gerrity, 1994). Given that this may be the case for any of the group members in a debriefing, mental health providers conducting debriefings must be prepared to do informal clinical assessment while monitoring and facilitating the flow of the group discussion. This is one of several reasons why debriefings typically are done with two co-leaders, either two mental health professionals or one professional and a "peer" (i.e., a rescue worker or survivor who is experienced in assisting in debriefings).

Two types of protocols are commonly used: **an initial debriefing protocol and a follow-up debriefing protocol**. The rationale for debriefing is that early intervention often is not alone sufficient to enable survivors or workers to verbalize and reflect upon their

intense experiences. A follow-up debriefing enables them to more fully incorporate a coherent personal understanding of these experiences, with the additional benefit of catharsis, an educational structure, and group support (Everly & Mitchell, 1992). However, there is no fixed number of debriefings that is a priori optimal for a given person or group. Each debriefing is an opportunity for the group, with guidance from the leaders, to assess how they're doing in making sense of the events and dealing with the emotions and stressors they've been encountering.

However, debriefing is neither psychotherapy nor counseling. At most, debriefers may meet 2-4 times with a group or an individual, with the goal of assisting those who need additional support or therapeutic guidance through referral for ongoing care with a local mental health professional or program.

Empirical Evidence for the Efficacy of Debriefing

Case reports and anecdotal evidence suggest that the process of debriefing may lead to symptom improvement (Dyregrov, 1997). Positive outcomes with psychometrically sound measure have been reported in randomised trails with hospitalized individuals (Bordow & Porritt, 1979) or their family members (Bunn & Clarke, 1979), and with survivors of a natural disaster (Hurricane Iniki; Chemtob et al., 1997); as did a quasi-controlled study with military personnel after Persian Gulf deployment (Ford et al., 1997). Equivocal results, with no clear benefit accruing from debriefing, were reported in studies with survivors of disaster (Kenardy et al., 1996), accident (Stevens & Adshead, 1996), violent crime (Rose et al., 1998), and miscarriage (Lee et al., 1996). Two studies, with accident survivors (Hobbs et al., 1996) and burn survivors (Bisson et al., 1997) report worse outcomes following debriefing than among non-debriefed controls. The most important conclusion to be drawn from these preliminary studies is that debriefing is not necessarily helpful, and that the specific way in which debriefing is delivered – the timing relative to the "critical incident," one-to-one versus family versus group formats, the number and duration of sessions, the education provided, the "alliance" between debriefer and debriefing participants, and the interaction among debriefing participants, among many factors – may be crucial to its success (Young, 1998). For example, Ford et al. (1997) found that a single large-group educational "debriefing" (similar in content to that offered by many single-session protocols) was ineffective but a series of 90-minute individual or family sessions (1 to 5) resulted in consistent reductions in stress symptoms and psychological problems. Debriefing is not necessarily a one-time-only intervention, and may be problematic for some individuals if it "opens up" emotional distress and thoughts of traumatic memories without providing sufficient assistance in reducing anxiety and acquiring a sense of personal mastery or closure.

Initial Debriefing Protocol (IDP)[3]

The protocol for an initial debriefing (IDP) usually consists of eight steps:

1. Preparation
2. Introduction
3. Fact phase
4. Thought phase
5. Reaction phase
6. Symptom phase
7. Teaching phase
8. Re-entry phase

Preparation

- If an agency has requested debriefing services, define process, ground rules, and objectives.
- Try to limit each debriefing group to 8-10 participants. The greater the number of participants attending, the less time each will have to actively participate. Depending on the setting, there may be people who wish to attend, but are unwilling to speak. Encourage active participation, however, suggest that participants who are too uncomfortable to talk may benefit from hearing about others' experience and from hearing information about stress reactions and stress management strategies.
- Arrange to work with a co-debriefer and discuss respective roles.
- Arrange for a private quiet room for 2 to 4 hours.
- Those in attendance should not be on call. Have educational / referral handouts ready.
- Schedule time for post-debriefing discussion with co-debriefer.

Depending on the number of participants and the time allotted, debriefers will necessarily have to evaluate how much time to spend on each phase and whether or not each participant will have equal time to speak.

Introduction

- **Introduce helpers/explain debriefing.** Debriefers begin with self-introductions (including brief description of disaster mental health experience) and explanation of the purpose of debriefing (clarifying that debriefing is not a critique of how participants have responded to the disaster). Explain that debriefing is an opportunity to talk about personal impressions of the recent experience, and learn about stress reactions and stress management strategies. Make clear that it is not psychotherapy.

[3] IDP developed by Bruce H. Young

- **Review confidentiality.** Personal disclosures are to be held in strict confidence by the group. Educational information may be shared outside the group. Inform attendees about mental health professionals' limits to confidentiality and the duty to report.

- **Explain group rules.** Inform attendees that no one is required to talk, but participation is encouraged. Agree on length of time. Inform attendees that everyone must stay until the end and that there will be no breaks. Advise that notes are not to be taken. Ask if anyone cannot meet these requirements and reconcile accordingly.
- **Facilitate participant introductions.** Depending upon the number of attendees, introductions may include name, hometown or vicinity, and whether or not there has been previous experience with disaster and/or debriefing.

Sample script

I'm _____ and I'm a stress management specialist here to meet with you along with my colleague _____ so we can take (specify approximate time available, usually 1-3 hours) to step back and reflect carefully on the experience you've all been through. For each of you the experience was unique, and taking a look at what you saw, heard, felt and thought about it is vital to your efforts to adjust to what has happened. Life may never be quite the same, and nothing we talk about should suggest that everything can just go back to what was "normal" in the past. However, what each one of us needs to do is to take the many pieces of the puzzle – what happened? what does it mean for me personally? what's normal to be feeling and thinking now? and, how do I go on with my life in a positive way? – and make sense of what this is about and what you need to do.

We will assist you with talking about your personal observations and thoughts, and in deciding what you need to do right now to continue putting the pieces back together the best way for you. If we can deal with some of the difficult parts of this experience – where you felt helpless, or trapped, or outraged, or terrified, or alone – then much of the rest will take care of itself. But this isn't therapy. We're not here to open you up to overwhelming anxiety or fear, or to criticize your reactions. Instead, we're here to talk about what's most affected you, and to see if together we can put together some of the pieces in this difficult puzzle.

It's important that everyone stays for the whole meeting, so you won't miss out on what others say and so we won't have to worry about anyone "missing in action." However, no one has to say anything unless they choose to, and silent attentive listening is valuable in itself. We'll hold to the rule of confidentially – what's said in here stays in here. It's important that we agree that any personal accounts shared in the group are not discussed elsewhere. There are two exceptions to this: In the course of the group, you may discover new ideas for coping with your job or workplace,

for example, a stress management technique. We encourage you to share this type of information with colleagues, friends, family. The other exception is if something comes up that indicates that someone is in danger of harming themselves or others, especially if the danger is to a child or elder, we will need to talk with that person privately. If there is a likely danger we'll need to report this properly so that safety is preserved.

In the time we have together today, we will use a structured process, referred to as debriefing, to review common stress reactions to a disaster, how such reactions can affect your relationships, works, sleep, appetite, energy, etc., and how you might anticipate and manage this stress over the next few days, week, and months.

Fact phase

Depending on the number of attendees, the fact phase of the debriefing involves asking participants to describe from their own perspective what happened, where they were, what they did, and what they experienced via their senses (sights, smells, sounds). With more than 12 people in attendance, it may be necessary to limit the number of people sharing their descriptions. Generally, survivors will have already told their story many times, distilling the facts (e.g., Earthquake survivors: "We ran out of the house and drove to my sister's house"). Ask them to fill in the account (e.g., "When you went to get the car keys, did you find them readily?" "When you opened the front door, did it open easily?"). Listen for what might not have been told before, for it may be in those moments, when their fear, helplessness, guilt, etc.,was particularly intense and requires validation.

Helpful questions:

- "Where were you when it happened?"
- "What did you do first?" "Then what did you do?"
- "What do you remember seeing, smelling, and hearing?"
- "Where was your family?"
- "Where were other people?"
- "Is there anything anyone said to you that stands out in your memory?"

Thought phase

In this phase, participants are asked to describe cognitive reactions or thoughts about their experience. In many instances, there are several events that have made a memorable impact. Target the most prominent thoughts or thoughts that have been ignored since the event. If there are more than 12 in attendance the debriefer may ask each participant to recall thoughts about the "the one thing you constantly think about."

During the course of descriptions, debriefers may interject to ask if other participants have had similar thoughts. The intent is to normalize common cognitive reactions.

Helpful questions:

- "When hearing about the approaching disaster, what did you first think?"
- "What were your first thoughts when the _____ struck?"
- "What ran through your mind when you first awoke to the loud noise of the _____?"
- "What ran through your mind during the evacuation?"
- "What are your thoughts now that the immediate threat is over?"
- "What thoughts will you carry with you?"

Reaction phase

In this phase, participants are encouraged to discuss the emotions they experienced during and after the disaster. This is the most challenging phase for facilitators. On one hand, the articulation of painful or frightening feelings and emotional catharsis is considered therapeutic for some survivors. On the other hand, the participants in the debriefing have not been previously assessed by the facilitators. The effect of not knowing participants' coping strengths, psychiatric history, quality of social support, and the disadvantage of having limited time and possibly no follow-up opportunity results in having to quickly and carefully consider how much emotional exploration is appropriate during the debriefing. It is recommended to err on the side of being conservative (i.e., not exploring emotional material that generates *overwhelmin*g feelings of vulnerability, helplessness, and anxiety).

Helpful questions:

"What was the most difficult or hardest thing about this (event) for you?"

"How did you feel when that happened?"

"What other strong feelings did you experience?"

"How have you been feeling since _____ happened?"

"How are you feeling now?"

"How has this experience affected your marriage, your work, your sleep, your interest in sex, your appetite, etc.?"

During the course of emotion descriptions, debriefers may interject to ask other participants if they have had similar feelings. As in the thought phase, the intent is to normalize common reactions.

Participants may be given an opportunity to discuss whether there have been any positive outcomes as a result of the event. Unlike the preceding questions, this is not an early disaster phase inquiry and in some cases is inappropriate. Stabilization and the regaining of a fair amount of equilibrium needs to have occurred in the survivor's life before possible positive effects can be appreciated. Depending on the severity of the trauma, and whether some degree of equilibrium has been restored, survivors may report a new appreciation for life, the disaster having provided an opportunity to re-evaluate and reset priorities.

Symptom (stress reaction) phase

In this phase, stress reactions are reviewed in a temporal context (i.e., what survivors experienced while the disaster was taking place, what stress reactions have lingered, and what they are experiencing in the present). Help participants recognize the various forms of stress reactions, taking care to avoid using pathological terminology.

Common stress reactions of primary victims:

- Emotional: Shock, anger, disbelief, terror, guilt, grief, irritability, helplessness, loss of pleasure in activities, regression to earlier developmental phase.
- Cognitive: Impaired concentration, confusion, distortion, self-blame, intrusive thoughts, decreased self-esteem / efficacy.

- Biological: Fatigue, insomnia, nightmares, hyperarousal, somatic complaints, startle response.
- Psychosocial: Alienation, social withdrawal, increased stress within relationships, substance abuse, vocational impairment.

Teaching phase

Actually, teaching occurs throughout the process of debriefing. Debriefers must assess what participants know and don't know and ensure that they have accurate information about stress reactions and stress management strategies. Given time constraints, not everything can be addressed and the debriefers will have to decide what information is most relevant to the participants.

Helpful questions:

"What has helped you to cope with this experience?"

"Who, if anyone, do you talk to?"

"Where do you get support for going through all this?"

"What seems to help you get through the particularly difficult periods?"

"Have you ever experienced anything like this before in your life?"

"What has worked before when you have experienced tremendous stress?"

Educational topics addressed during debriefing may include:

A. **Definition of traumatic stress**

Quantitative and qualitative dimensions (DSM-IV criterion A; sensory exposure; phenomenology of loss – loved ones, property, perceived control, and meaning).

B. **Common stress reactions**

In addition to teaching about the reactions previously listed, it is useful for survivors to learn about the phases of disaster and childrens' and older adults' reactions.

"Fight-flight-freeze" response Describe how survivors may become "wired" with physical energy: heart pounding, muscles tensed up, breathing faster, sweating. Point out that it might feel like either irritation and anger (the desire to "fight back"), fear and worry (the desire to "flee" from danger), or so much fear that it causes temporary immobilization ("freezing"). Explain that each response has potential survival value. "Fighting back" can mean taking actions to stop further harm from happening. "Taking flight" can mean finding a safe place to "ride out the storm." "Freezing" can buy time to evaluate the situation and plan an intelligent response. Inform participants that survivors often feel guilty or ashamed for having reacted in these normal ways, believing that they should somehow have been immune to the body's healthy response of getting "geared up" automatically in the face of danger. In fact, it is the emotional shock of trauma – the terror, grief, helplessness, horror, and confusion – that is the real problem, not the normal reactions of fight, flight, or freezing.

Helplessness Describe how thoughts and feelings of helplessness are normal and realistic during trauma, but if the trauma survivor does not find constructive ways to regain a meaningful sense of positive control in life, helplessness can become either chronic hopelessness and depression, or a style of over-controlling that hurts and alienates other people (and the trauma survivor, too). Assure participants that most people would prefer to believe they are immune to trauma, yet trauma is a stunning emotional shock to even healthy individuals.

Disillusionment Perhaps the greatest shock for many survivors is realizing that life, and other people, can be horribly cruel and out of control. Trauma often forces survivors to endure unspeakable ugliness and tragedy. Trauma sometimes forces survivors to make impossible choices that violate basic moral values and religious beliefs. Many survivors feel "dirty" or "empty" because their trust in people, in God, and in themselves seems betrayed.

Participants may need to be reassured that feelings of horror are an indication of compassion and conscience, not of weakness. Feelings of vulnerability during and after trauma may be indication of good "reality testing" – a healthy, though very painful and disturbing, recognition of the full extent of trauma's emotional shock. Stress, helplessness, and shock of trauma often lead to reactions of grief, guilt, confusion, irritability, sleep problems, and feelings of disorientation. Assure participants that such reactions are best dealt with constructively – sometimes medically, sometimes through counseling, and/or through personal and family support.

C. **Factors associated with adaptation to trauma**

1. Degree of sensory exposure (severity, frequency, and duration).
2. Perceived and actual safety of family members/significant others.
3. Characteristics of recovery environment (existence/access/utilization of social support).
4. Perceived level of preparedness.
5. Pre-disaster level of psychosocial functioning (coping efforts).
6. Pre-disaster level of psychosocial stress (vulnerability/resilience).
7. Interrelationships among factors of personal history, developmental history, belief systems, and current and

past stress reactions, including previous exposure to trauma (war, assault, accidents).

D. **Self-care and stress management**

1. Relationship between behavior and stress (exercise, eating habits, receiving and giving social support, relaxation techniques).
2. Self-awareness of emotional experience and selected self-disclosure.
3. Stress-related disorders (PTSD; other disorders which may be exacerbated by stress).
4. Parenting guidelines (how to enhance coping of children).
5. Disaster preparedness (how to be better prepared next time).
6. When and where to seek professional help.

E. In sum, teaching throughout a debriefing is intended to help participants gain a better understanding of their reactions and the reactions of others (e.g., children, older adults, co-workers), to anticipate the course of normal recovery, to better understand useful stress management strategies, and identify when and where to get additional support.

Re-entry phase The final phase of the debriefing is allotted to a discussion of unfinished issues and reactions to the debriefing, along with a summation of the debriefing, a reminder about confidentiality, and a clarification of the referral process.

When possible, a follow-up debriefing should be scheduled to take place within two weeks. The protocol for follow-up debriefings is described on the following page.

Debriefers should remain available after the debriefing to allow anyone in attendance to meet with the debriefers privately.

Note: *Debriefings in the "real world" seldom proceed directly in the sequence of steps described. Nor should they. It is not uncommon for participants to talk about feelings in the "fact" phase, or not be aware of a key "fact" until the group is well into a later phase. Experienced debriefers balance re-orientation to the current focus with validation of the significance of whatever the participant is sharing at that moment. Experienced debriefers also incorporate appropriate material from one phase to another, for example commenting briefly on how participants' reactions illustrate expectable stress responses.*

"Debriefing" Protocol for Large Groups

Occasionally, circumstances require meeting with a large (25-50) number of survivors. Before committing to undertake debriefing a large group, explore the possibility of dividing the group into small groups by offering more debriefings. For example, if there are 30 people, see if three debriefings can be held for groups of ten. A modification of the process and content of the eight steps used in formal debriefings is necessary when debriefing a large group. The primary objectives of such meetings are to provide information about common reactions to traumatic stress, useful stress management strategies, signs that suggest individual help may be beneficial, and where to get additional information or help. Even though not everyone will be able to participate, encourage participation and interaction and relate educational material to their experiences.

Substance Abuse Prevention

Post-traumatic stress syndrome is often accompanied by one or more other psychiatric syndromes such as depression, panic, and or substance abuse. A minority of survivors increase their use of alcohol, illicit drugs, and medication following disaster exposure. However, survivors who have persistent difficulty with post-traumatic stress symptoms or PTSD are at particular risk for problematic use of alcohol or other drugs. Substance use can be a means of attempting to:

- avoid bad memories
- relax in the face of distressing emotional and physical tension
- socialize despite feelings of isolation or insecurity
- enjoy activities despite feelings of emotional emptiness or numbness
- sleep without nightmares or insomnia

Helpful questions:

"How have you coped with those difficulties?"

"Have you noticed any particular changes in your ways of coping or your lifestyle?"

"Have you found yourself drinking alcohol more often, or in a different way, than before the disaster?"

"Has this been a problem for you, or have others told you they were concerned?"

Unfortunately, alcohol or drug use tend to exacerbate and prolong post-traumatic stress symptoms (both for biological and psychological reasons) rather than providing genuine relief.

Disaster mental health workers may play a significant role in helping prevent potential alcohol and drug problems by taking the following steps:

1. Ask survivors about drinking and drug use habits as part of assessment and helping activities. It is challenging to make such inquiries in non-clinical settings, and your sensitivity to survivors' personal or cultural concerns about disclosing substance use is important. For example, it is possible to ask about substance use in response to a survivor's statement

that she or he has felt extremely tense or had difficulty sleeping or enjoying being with people.

2. Educate survivors about the risks of increasing substance use as a "self-medication" strategy following disaster exposure. Distinguish this from alcoholism or addiction, but alert survivors to the risk for developing a habit that can lead to longer-term problems. Many survivors recognize thoughts or urges to drink alcohol or use substances as a way to "take the edge off," to "let down and take a break," or to "knock me out so I can get some sleep." It can be helpful to empathize with the desire to reduce tension and relax, while also discussing that even strategic use of alcohol or substances often tends to have the opposite effect of increasing physical and emotional tension (e.g., increasingly sleeplessness or reducing the restorative value of sleep; increasing irritability). Survivors often appreciate the distinction between a temporary need to be careful about substance use during the stressful wake of a disaster versus a chronic problem with alcoholism or addiction.

3. Recommend that survivors adhere to physician-determined levels of prescribed medications and abstain from or limit alcohol use (i.e., 1-2 drink per-day maximum, no drinking on a daily basis, and frequent non-drinking periods). It is helpful to remind survivors that caution about substance use is one of several ways to be as alert and effective as possible during the recovery period after disaster.

4. Assess survivors' past and current alcohol, drug, and medication use more thoroughly if quantity, frequency, or timing of consumption suggest a potential abuse. Screen such individuals with instruments such as the CAGE (Liskow et al., 1995).

Helpful questions (CAGE):

"Have you ever wanted to cut down on consumption?" (C)

"Have other persons annoyed you with comments about your consumption?" (A)

"Have you felt guilty about the effects on your life?" (G)

"Have you needed a drink/hit/etc. as an eye-opener after drinking/using the day before?" (E)

Individuals who endorse two or more of the CAGE items are at risk for alcohol or substance use problems. Neither the CAGE nor any other brief substance use screen is an infallible predictor of clinically problematic substance use, so it is important not to assume that endorsement of the screen items indicates an immediate or critical substance use disorder. Instead, a first step is to informally and privately discuss with the survivor the circumstances surrounding the incidents that led her or him to endorse the screen items. (e.g., *"You noted that people have annoyed you with comments about your consumption of alcohol or other substances. What actually happened in those conversations, and what was it that*

annoyed you? ... Did something someone else said cause you to worry that you might have a problem with using [substance(s)]? ... Have you found that your consumption is different, in the amounts or the ways you are drinking/using, than what's usual for you? Do you think this may have something to do with feeling stressed? ... Let's look at what might relieve some of this acute stress (which is absolutely normal but can be very difficult) without changing the way you use substances.")

5. Ask the survivor if she or he would like any additional information or support in dealing with stress and with changes in substance use since the disaster and provide the survivor with contacts to self-help (e.g., 12-step, Rational Recovery) and professional (e.g., local substance use counseling programs or practitioners) resources if she or he requests these or if she or he describes a longstanding or severe problem with substance use.

   Chronic substance use problems, including subthreshold problems that have not been detected or deemed sufficient to warrant treatment, are often exacerbated to a level in need of clinical care after a disaster. Hence, the recovery period after disaster can be an important opportunity to address critical health problems as a result of years of "hidden" or "silent" substance abuse. Starting substance use treatment is in itself stressful, so it is important not to press the survivor to immediately undertake treatment—recommending treatment tends to elicit a negative response under the best of circumstances, let alone when the individual is stressed by a recent disaster. Instead, your role is to provide the survivor with a professional appraisal (that substance use appears to have had problematic consequences) and nonjudgmental guidance (that self-help and professional resources are available when the survivor feels ready and able to utilize them, and that this can contribute to recovering from the stress of disaster).

Teaching Relaxation Techniques

Who is willing to relax when there is a disaster to deal with? The inordinate demands upon survivors often result in resistance to any form of relaxation. Survivors often feel a need to stay alert and on guard in order to cope with the continuing stressful circumstances. They may fear that "slowing down" will evoke distressing memories and feelings that they understandably want to avoid (e.g., "I'm keeping busy and keeping my mind busy so I don't dwell on the awful pictures that keep popping into my mind").

Nonetheless, it is essential that survivors, families, rescue and support workers, and disaster mental health personnel find ways to take breaks from the many tasks at hand and use brief relaxation techniques to make the most of their brief opportunities to refresh themselves physically and emotionally. Clinicians can provide survivors with a practical orientation that (a) conveys empathy for their reluctance to relax (e.g., *"It's very tough to let down your guard after a disaster, it's been such a shock and there's so much to do just to keep a semblance of normal life going. The body and mind often take several days or even weeks before the shock wears off. And since no one can control what happens in a disaster, we all want to do everything we possibly can do now that it's possible to recover and rebuild our lives."*), and (b) describes relaxation as a method of enhancing alertness, energy, and clarity of decision-making (e.g., *"In order to be as effective as possible in the recovery period, your mind and body need ways to re-charge on a regular basis. Relaxation is as important as good nutrition or sleep, and relaxation actually can be the best way to help your body make use of nutritious foods and get real sleep."*)

A powerful way to demonstrate the benefits of relaxation is to provide a brief sample to the survivor. This can be done in a matter of just a few minutes. As a disaster mental health worker, you must be prepared to quickly present the rationale for relaxation, address resistance to it, and teach practical relaxation methods in environments that may be noisy and chaotic. Whenever possible, however, find as quiet a place and as uninterrupted a time as possible, because noise and interruptions trigger startle responses and hyperarousal that can make relaxation seem impossible or unhelpful.

We recommend the following guidelines for teaching relaxation techniques to survivors:

1. Inquire about sleeping patterns and level of fatigue. Detemine how tension and recurrent distressing thoughts or feelings interfere with sleep and feeling rested.

2. Inquire about previous and current coping methods. Inquire about nutrition, sleep, exercise, recreation, enjoyable activities, time with family and friends, and any other sources of emotional and physical re-charging that have been helpful in the past. Take note of common sense remedies the survivor has found helpful for managing stress.

3. Assess concerns about relaxing and using relaxation methods. Do not attempt to argue against these concerns, but instead help the survivor clarify them in terms of (a) the belief that it is impossible to relax due to intense continuing stress, (b) a fear that letting down and relaxing will compromise the ability to cope effectively, (c) a fear of being overwhelmed by intrusive memories or emotions, (d) bad past experiences with relaxation or related (e.g., hypnosis) techniques. The first two components can be addressed in an empathic and validating rationale for relaxation (see above).

   Fear of overwhelming intrusive re-experiencing should be carefully assessed, to determine if the survivor may be in need of more intensive counseling. These fears often are understated initially, as a function of avoidant coping and emotional numbing (e.g., *"I just don't feel comfortable letting down my guard. I start to feel depressed or anxious and that bothers me. It's no big deal, I just keep myself going and those feelings don't build up"*). It is not advisable to teach relaxation methods that involve the potential for trance-like dissociation (e.g., guided imagery, autogenics) with survivors for whom intrusive re-experiencing is problematic. Instead, more present-focused and concrete methods (e.g., the brief relaxation response; brief breathing exercises; progressive muscle relaxation) are recommended, in order to enhance the survivor's sense of control while also increasing physical relaxation.

   Negative past experiences with relaxation or related techniques should be taken seriously. First, this may be an indication of psychological or psychiatric problems that should be addressed separately from advice or assistance concerning relaxation. For example, individuals with bipolar disorder may find that systematic relaxation seems to trigger or intensify either manic or depressive distress, and it is the

disorder and not relaxation per se that requires clinical attention. Second, negative experiences due to having been taught ineffective or poorly selected relaxation techniques must be countered by the selection of methods that are better suited to this particular individual. No relaxation method is 100% effective for all persons, so matching the approach to the individual is essential—and information about past experiences can guide the clinician in selecting approaches that are better suited to that particular survivor.

4. Provide rationale for relaxation (i.e., enhancing alertness, energy, and clarity of decision-making).
5. Begin instruction and demonstration of techniques (e.g., muscle relaxation, conscious breathing, autogenics, visualization, etc.). Remember, the circumstances and/or settings that you will be teaching in are, more often than not, far from ideal. You may have as few as five and usually no more than fifteen minutes to demonstrate the value of relaxation. The challenge is to efficiently facilitate the experience of relaxation in the midst of a chaotic environment. When possible, take the survivor aside to a relatively quiet and more private place than typically found in the midst of most relief centers or shelters (e.g., a brief walk outside; a corner somewhat removed from the middle of a busy relief center).
6. When possible, have handouts available that describe the techniques for the survivor to take and refer to when using the relaxation methods in the future.

Sample script to use with survivor

"It's been non-stop for you since the (_____disaster) and it sounds like you're more tired than you've been in a long time. There's much you have to do to get things straightened out. Given all these demands and changes, it's vital that you find ways to get breaks from all this, even if it's just for 5 or 10 minutes a day. Are you able to get this kind of break? ... What do you do to relax when you do take a break? What have you found that helps you to slow things down and recharge yourself? ... Have you ever found a down-to-earth method like taking a few slow deep breaths to be helpful? ... What about closing your eyes and thinking about a quiet peaceful place or activity? ... Have you had any frustrating or negative experiences trying to relax or using relaxation methods? ... Would you like to try a brief relaxation technique that you can use on your own?"

Helping Establish Survivor Self-Help Groups

One of the ways in which survivors may reestablish their sense of control is through the formation and action of self-help groups. These groups serve to direct the energy of survivors toward providing mutual support, addressing practical post-disaster problems, and developing action plans regarding common concerns. Therefore, an efficient use of disaster mental health resources is to facilitate the operations of self-help groups. Schools, religious organizations, counseling and mental health centers, senior centers, women's centers, parent-child centers, hospitals, and neighborhood organizations often have ongoing support groups or establish new groups specifically for disaster survivors.

To support self-help group establishment and operation, disaster mental health workers can:

- Contact newly developed self-help groups and offer support services
- Provide consultation to groups
- Provide specialty knowledge (e.g., stress management)
- Help with access to resources
- Help publicize groups
- Help groups network
- Accept referrals for more intensive assessment or counseling of group participants for whom group participation is not sufficient or appropriate

Self-help groups can serve to:

- Provide emotional support, validation, and enhanced sense of community
- Facilitate information sharing
- Provide opportunities for participants to help others
- Provide enhanced sense of personal control
- Increase political power

Disaster mental health workers should take care to:

- Respect group autonomy and avoid taking the leadership role
- Refer to the group as a self-help group, or other member generated name, and avoid labeling it as "a mental health group."

When to Make Mental Health Referrals

As noted in the preceding pages, there are a variety of factors which place trauma survivors at risk for development of continuing emotional problems. However, referral for mental health services is inappropriate for many individuals who may appear to be at risk, because many of them will not go on to develop PTSD or other problems.

Referral is, however, clearly indicated for some persons. The American Red Cross has listed a variety of circumstances in which the disaster mental health worker should refer a survivor to local mental health professionals for specialized evaluation and care *(Disaster Mental Health Services I Participant's Workbook, American Red Cross, 1995, p. 21).* According to ARC guidelines, immediate referral for community treatment should be considered when a disaster survivor demonstrates:

- Significant disturbance of memory
- Inability to perform necessary everyday functions
- An inability to care for one's personal needs
- Inability to begin cleanup or apply for necessary assistance
- Inability to make simple decisions
- Preoccupation with a single thought
- Repetition of ritualistic acts
- Abuse (rather than "misuse") of alcohol or drugs
- Talk that "overflows" – shows extreme pressure of speech
- Suicidal or homicidal talk or actions
- Psychotic symptoms
- Excessively "flat" emotions, inability to be aroused to action, and serious withdrawal
- Frequent and disturbing occurrence of flashbacks, excessive nightmares, and excessive crying
- Regression to an earlier stage of development
- Inappropriate anger and / or abuse of others
- Episodes of dissociation
- Inappropriate reaction to triggering events

Finally, *medical referral* will be to address life-threatening medical conditions.

Pharmacotherapy Following Disaster[4]

There are several matters to address when considering pharmacotherapy for survivors of recent disasters who present clinically as acute psychiatric emergencies.

Diagnostic Assessment and Management

A natural or technological disaster may precipitate abrupt changes in mood or behavior that demand clinical attention. Mental health services following a disaster are generally directed toward normal people, responding normally, to very abnormal situations. However, abnormal reactions are neither diagnostic of an underlying psychiatric disorder nor indications of the need for pharmacotherapy. Therefore, the clinician assessing such individuals should assume, until proven otherwise, that the patient does not suffer from a major psychiatric disorder and that symptoms associated with increased psychological and physiological arousal will resolve without medication within a reasonable amount of time. It is recommended that survivors receive psychoeducational information about common stress reactions and stress management strategies as well as individual or group debriefing as soon as possible. This is particularly true when a) the trauma of the disaster is marked by ongoing danger or intense sensory reminders (e.g., earthquake aftershocks, a series of storms, ongoing inter-racial tension following race riots), b) the trauma of the disaster has been compounded by a rescue or evacuation process marked by chaos and disorganization; c) the patient has suffered a physical injury; d) the patient does not have an adequate social support network, or social support has been severely compromised by disaster fatalities and injuries, and e) the patient appears numb and unresponsive and fails to exhibit the normal signs of distress.

Consider debriefing as a diagnostic screening process, through which one can identify those individuals who will require more intensive and prolonged clinical attention. Pharmacotherapy should only be considered after there is good evidence that standard debriefing approaches are ineffective. At this point, diagnosis must be considered carefully. Although it is certainly possible that the patient is suffering from an acute post-traumatic stress (PTS) syndrome, other alternatives must be ruled out before reaching this conclusion.

---

[4] Friedman, M.J. Many of the suggestions in this section are based on an article previously written (see, Friedman, Charney & Southwick, 1993).

Patients in their late teens or early twenties are at an age when people with schizophrenia, mania, depression, or panic disorder exhibit their first clinically significant episode of illness. In that regard, clinicians must consider the possibility that the disaster has accelerated the onset of a psychiatric illness that would have declared itself sooner or later.

Organic conditions must also be considered, especially among patients who have suffered a head injury, lost consciousness, or experienced fluctuations in their mental state following the disaster. In that regard, the clinician must rule out a delirium, subdural hematoma, seizure disorder, sleep deprivation, or some other neurological problem.

Finally, one must rule out an alcohol or drug related problem such as intoxication or a withdrawal syndrome. People who use alcohol or drugs to cope with ordinary stressors are very likely to utilize them during a disaster as long as their supplies hold out. These same people are at risk to develop a clinically significant withdrawal syndrome, if the disaster has suddenly made their alcohol or drugs unavailable.

If the patient has not responded to debriefing, psychoeducational information, or stress-management strategies, and does not appear to exhibit a non-PTS psychiatric, neurological, or alcohol/drug-related psychological abnormality, it is time to consider that s/he is experiencing either acute PTS or a severe exacerbation of chronic PTSD. Even under such conditions, it is best to withhold all medications for the first 48 hours, when possible. Such a drug-free interval will provide an opportunity for the patient to respond to the structure and safety of a clinical milieu, a shelter, or some other safe environment, catch up on lost sleep if needed, and achieve psychological stability.

There are important exceptions to this guideline. Rapid initiation of pharmacotherapy is indicated for patients who present serious management problems, who are a danger to themselves or others, and who are extremely agitated, psychotic, noncompliant, or disruptive. A short acting anti-anxiety agent such as the benzodiazepine lorazepam (Ativan) is the treatment choice under these conditions. Unlike diazepam (Valium) lorazepam can be administered intramuscularly and has a rapid onset of action. Generally, patients who fail to respond to lorazepam are psychotic rather than extremely anxious and require aggressive treatment with an antipsychotic drug such as haloperidol (Haldol) which can be administered orally, intramuscularly, or intravenously. Haloperidol is a better choice than many other antipsychotic drugs because it has few orthostatic or anticholinergic side effects.

Pharmacotherapy Treatment of Post-Traumatic Stress Syndromes

It must be emphasized that there are no published controlled trials on pharmacotherapy for acute post-traumatic stress. In fact, there are only two clinical articles in print, both concerning pharmacotherapy for acute psychiatric emergencies among military personnel (Ritchie, 1994; Friedman, Charney, and Southwick, 1993). Major differences between military personnel in a war zone and civilians following a disaster are that military personnel are more likely to be healthy young adults who have been prepared for traumatic situations. Military personnel are less likely to have chronic medical or psychiatric conditions and much less likely to be taking any kind of medication on a regular basis. Therefore, a civilian post-disaster population represents a much more diverse set of problems. Special issues such as pediatric, geriatric, and chronic medical concerns are beyond the scope of this section, but demand particular attention. The treatment guidelines for PTSD, presented below, will not address these special issues but they should be kept in mind. In general, starting doses should be much lower and titration of dosage should be done slowly and cautiously with youngsters, oldsters, and people with chronic medical illnesses who are taking medication on a regular basis.

There has been remarkable progress in our understanding of the neurobiological basis of acute stress and chronic PTSD (Friedman, Charney, and Deutch, 1995). Among the neurobiological abnormalities detected thus far, the most well established involve the adrenergic nervous system, the hypothalamic-pituitary-adrenocortical (HPA) axis and probably the serotonergic and endogenous opioid systems. Given the lack of controlled trials mentioned earlier, the following recommendations are extrapolated from the latest information on pharmacotherapy for PTSD (Friedman, 1996).

Several theorists have suggested that there are two different types of acute war zone-related traumatic stress (Catherall, 1989; Keane, 1989; Rahe, 1988; Solomon et al., 1987) and a similar nosology for traumatic reactivation stress among disaster victims (Hiley-Young, 1992). The first is a dramatic hyperarousal state marked by anxiety, agitation, irritability, panic, phobic avoidance, startle reactions, and occasionally fearfulness or even paranoid excitement. The dominant neurobiological abnormality under such conditions is dysregulation of the adrenergic nervous system. Conventional wisdom based on military psychiatric experience would suggest treatment with a benzodiazepine anxiolytic such as lorazepam (Ritchie, 1994; Stokes, 1990). Should such treatment be sustained for a period of days or weeks, clonazepam is the best benzodiazepine to use because it has a longer half-life, does not produce the rebound anxiety of shorter acting drugs, and has a

much lower abuse potential than other benzodiazepines (Friedman, Charney, & Southwick, 1993).

Rather than benzodiazepine treatment, the alpha-2 adrenergic agonist clonidine offers a number of advantages. First of all, it will directly antagonize the PTSD hyperarousal state by reducing excessive adrenergic activity through a direct action on adrenergic neurons in the brain. In addition, clonidine acts rapidly and has no abuse potential. There are theoretical reasons to speculate that clonidine, through its direct dampening effect on the acute stress response, might reduce the subsequent risk of developing PTSD, but there is no data to support this conjecture at this time. Clonidine should not be administered to patients with cardiovascular problems or to patients with low blood pressure due to pre-disaster illness or post-disaster injury. Another drug that might be useful to reduce the excessive adrenergic activity associated with the PTSD hyperarousal state is the beta-adrenergic antagonist, propranolol. It has the same advantages and disadvantages as clonidine but may not be as effective.

The second type of acute post-traumatic reaction described by Catherall (1989), Keane (1989), Rahe (1988), and Solomon et al. (1987) is characterized by withdrawal, dysphoria, PTSD-like avoidant/numbing symptoms, impacted grief and social isolation. This type of acute reaction is thought to have a more serious prognosis than the hyperarousal state because it is more likely to progress to full-fledged PTSD. Given the prominence of avoidant/numbing symptoms in this clinical presentation, the best drug to choose is a selective serotonin reuptake inhibitor (SSRI) such as fluoxetine (Prozac) or sertraline (Zoloft). Of all drugs tested in PTSD thus far, only the SSRIs appear to have efficacy against the avoidant/numbing symptoms of PTSD. These drugs have other advantages as well since they are potent antidepressants and antipanic agents (Friedman, 1996). There is even preliminary evidence that these drugs will reduce the alcohol abuse and dependence that is often associated with PTSD (Brady, 1995). A major disadvantage of SSRIs in a post-disaster situation is that they do not act quickly and may require several weeks to exert their clinical effects.

Lack of rapid onset of action is also a problem with other drugs that have been successful in PTSD treatment such as monoamine oxidase inhibitors (MAOIs) or tricyclic antidepressants (TCAs). In general, these drugs have been shown most effective in countering re-experiencing symptoms of PTSD such as intrusive recollections, traumatic nightmares or flashbacks (Southwick et al., 1994). In addition, MAOIs are not recommended for people who cannot remain alcohol or drug free or who cannot observe MAOI

dietary restrictions. Adherence to an MAOI diet may be particularly difficult following a disaster, if food is scarce and the choice of food is limited.

Summary

Whenever possible pharmacotherapy should be delayed for at least 48 hours. During that period patients should receive individual or group debriefing as soon as possible. Individuals who do not respond to debriefing must be carefully evaluated for non-PTS psychiatric, neurological or alcohol/drug-related psychological abnormalities. If careful assessment indicates that the individual is suffering from acute PTS, one must distinguish between the acute hyperarousal reaction and the acute dysphoric/avoidant reaction. Clonidine or lorazepam are generally indicated for individuals who require pharmacotherapy to control the acute hyperarousal state. If dysphoric/numbing symptoms are prominent, it would be best to institute SSRI treatment at an early stage so that the drug's full therapeutic effect may develop as soon as possible.

Table 1. Potential Medications for PTS-Related Symptoms

Target Symptom	Medication	Dosage	
Hyperarousal	Clonidine 40-240mg/day	0.1-0.6mg/day Clonazepam Lorazepam	Propranolol 1-6 mg/day 1-8mg/day
Agitation	Lorazepam Haloperidol	1-8mg/day 2-20mg/day	
Dysphoria/Numbing	Fluoxetine Sertraline	20-80mg/day 50-200mg/day	
Re-experiencing	Phenelzine (MAOI) TCAs	30-60mg/day 50-300mg/day	
Insomnia	Flurazepam Temazepam	30mg/hs 30mg/hs	

RESTORATION PHASE INTERVENTIONS

As communities enter the restoration phase of disaster, it is hoped that most survivors will have received basic education about resources for addressing practical and emotional needs, and about stress symptoms and coping. Also, they should have received formal and informal opportunities to discuss their traumatic experiences and emotional reactions.

Despite natural recovery mechanisms or disaster mental health relief efforts, evidence suggests that years after disaster as many as one in two survivors have chronic or delayed PTSD or other disaster-related psychological problems (often in the form of recurrent intrusive re-experiencing and associated distress). During the restoration phase the focus of helping shifts to the identification of individuals and families who continue to experience emotional problems. Services are generally provided under the auspices of the Crisis Counseling Program described on page 138.

A vital component of these crisis counseling programs is ensuring that contract providers receive specialized training, many of whom have clinical skills unrelated to those needed in disaster mental health. As providers receive training, they in turn can assist indigenous health care, social service, and advocacy personnel in ongoing identification of survivors experiencing problems, through advising on implementation of screening procedures in health services, and by training appropriate individuals and organizations in assessment of disaster-related PTSD.

- Disaster recovery requires not only relief from initial symptomatic distress but restoration of key individual, relational, organizational, and community-wide re-sources.

  Erikson (1976); Freedy et al. (1992, 1994); Hobfoll (1991); Hodgkinson (1989); Lopez-Ibor (1987); Quarantelli (1986); Shalev et al. (1993); Wright et al. (1990).

- Social support is of greatest benefit in the restoration phase.

  Cook & Bickman (1990); Palinkas et al. (1992).

Screening Instruments

In the months and years following the disaster, medical and mental health care providers in the affected communities will be working with many disaster survivors who continue to experience distressing emotional effects. When acute danger and distress is no longer the primary priority for survivors and rescue workers, a more thorough assessment of the psychological functioning and coping resources of survivors can provide important information. Assessment of the relationship between traumatic aspects of the disaster and psychological functioning can serve to guide responses to individual survivor needs, as well as treatment program design.

As supplements to clinician interview, two brief measures (on the next pages) may be given to disaster survivors in community medical or mental health settings: the Personal Experiences in Disaster Survey (PEDS; Young & Ford, 1998) and a modified version (PCL-D) of the PTSD Checklist (PCL; Weathers, Litz, Huska, & Keane, 1994). The PEDS focuses on helping identify the nature of the stressful experiences experienced by the disaster survivor, and the degree of the survivor's social support. The PCL-D permits an assessment of levels of PTSD symptomatology, and helps guide the decision about whether to treat or refer for post-traumatic stress disorder. Respondents rate, on a 5-point scale, the extent to which they have been troubled in the past month by each of the 17 DSM-IV symptoms of PTSD. The PCL has demonstrated reliability, validity, and diagnostic utility with some trauma populations (e.g., combat veterans civilian victims of violence). A cutoff score of 51 or greater has been shown to identify PTSD diagnoses (using a PTSD structured interview as the criterion) with sensitivity and specificity greater than 95%.

You may also wish to select a measure that reflects the specific experiences likely to have occurred to survivors and rescue workers in a specific disaster, adding items from the more comprehensive PEDS to supplement the assessment. Some useful measures:

Sample measures to assess disaster experiences

- **Adult Measures:**

Self-Report:	Contact with Fire (Koopman et al., 1994)
Self-Report:	Firefighter Inventory of Disaster (McFarlane, 1987)
Self-Report:	Oil Spill Exposure Index (Palinkas et al., 1992)
Interview:	Disaster Supplement (North et al., 1990; Solomon & Canino,1990)
Interview:	Air Crash Rescue Exposure Index (Bartone et al., 1989)
Interview:	Disaster Stress Scales (Green et al., 1983)
Interview:	Family Responsibility / Guilt Indices (Cella, Perry et al., 1988)

Examination: Burn Severity (Perry et al., 1992)

- **Child Measures:**
  Self-Report: Hurricane Related Traumatic Experiences (HURTE) (Vernberg et al., 1996)
  Interview: Disaster Supplement (Earls et al., 1988)
- **Adult Measures:**
  Self-Report: PTSD Symptom Scale (Fua et al., 1993)
  Self-Report: Davidson Trauma Scale (Davidson et al., (1997)
  Self-Report: Impact of Events Scale-Revised (Weiss & Marmar, 1997)
  Interview: Clinician Administered PTSD Scale (Caps; Blake, 1994)
  Structured Clinical Interview for DSM-IV (SCID; Spitzer et al., 1996)

Sample measures to assess risk of post-traumatic stress disorder

- **Child Measures:**
  Self-Report: PTSD Reaction Index (Pynoos et al., 1987)
  Interview: Clinician Administered PTSD Scale for Children (CAPS-CA; Nader, 1997)

Personal Experiences Disaster Survey (PEDS)

Name: _____ Age: _____ Gender: M F Race/Ethnicity: _____ Marital Status: _____

Today's date: _____ What date did the disaster begin? _____

Please briefly describe the crisis or disaster: _____

Thank you for taking the time to fill out this survey. We realize from our own disaster experience that you have many things to do. Disasters and crises are different for each person, and they don't end all at once. Some reactions occurred to you or your family during the recent crisis or disaster, and some are still continuing now. For each question, please check either yes or no. If you check yes, please circle one of the five descriptors (not at all; rarely; sometimes; often; very often) to answer the question about your reactions. Because this is a standardized disaster survey, there may be questions that do not apply to your experience.

PART I

- **Did you experience physical injury requiring treatment?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did anyone of your loved ones experience physical injury requiring treatment?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did you know or witness other people become injured?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Was your life or health in severe danger?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were anyone of your loved ones' lives or health in severe danger?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Was there a period of time when you were uncertain about the welfare of loved ones?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did you feel "spaced out", in a daze, or emotionally numb?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

Personal Experiences Disaster Survey (Page 2)

- **Were any loved ones' terrified or horrified?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were any loved ones' "spaced out", in a daze, or emotionally numb?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Was your home severely damaged or destroyed?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were important personal property or belongings severely damaged or destroyed?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Was your home or business looted?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did you have to defend your home or business from looters?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were racial slurs directed at you?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did anyone physically threaten you?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did anyone physically assault you?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did anyone direct racial slurs toward you?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

Personal Experiences Disaster Survey (Page 3)

- **Did you physically strike anyone?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did you fire a gun?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Was your workplace badly damaged or destroyed?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Was your community badly damaged or destroyed?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were you unable to get food, liquids, or shelte**r? ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **As a result of the disaster, do you have major financial problems?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were you temporarily separated or cut off from family members or close friends?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were you exposed to toxic chemicals or gases?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were you exposed to other strong odors (e.g., smoke, mildew, dust)?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Do you have children under the age of 18 years old who were exposed to the disaster?** ☐ **YES** ☐ **NO**

- **Was there a fatality in your family?** ☐ **YES** ☐ **NO**

Personal Experiences Disaster Survey (Page 4)

- **Did you witness any fatalities?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were you exposed to bodies or people who were horribly physically injured or disfigured?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were you exposed to terribly damaged, burned or destroyed buildings or vehicle?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Were you exposed to people acting violently or destructively (e.g., rioting, looting)?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did you have any other experience that caused you to feel terrified, helpless or horrified?** ☐ **YES** ☐ **NO** ☐ In the Disaster ☐ Continuing now
  If yes, please briefly describe: _____
  _____

- **Were you unable to safely travel in and around your community?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did you have to evacuate your home/community?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Have you experienced a spiritual crisis?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Has your marriage (primary relationship) been severely stressed or troubled?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Has your relationship with your children been severely stressed or troubled?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

Personal Experiences Disaster Survey (Page 5)

- **Has your relationship with your neighbors and friends been severely stressed or troubled?** ☐ **YES** ☐ **NO**
  If yes, did this cause you to feel terrified, helpless, or horrified?
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

PART II

In this section, the survey consists of questions related to social support.

- **Do you feel closer to some people?** ☐ **YES** ☐ **NO**
  If yes,
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Did you receive a lot of support from others?** ☐ **YES** ☐ **NO**
  If yes,
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Do feel there has been at least one person who understands the effects of the disaster on you and your family?** ☐ **YES** ☐ **NO**
  If yes,
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Do you feel there are several people who understand the effects of the disaster on you and your family?** ☐ **YES** ☐ **NO**
  If yes,
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Do you attend church or a temple?** ☐ **YES** ☐ **NO**
  If yes,
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Have your fellow church or temple members been supportive?** ☐ **YES** ☐ **NO**
  If yes,
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Have you talked with a counselor about the effects of the disaster on you/family?** ☐ **YES** ☐ **NO**
  If yes,
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

- **Have you found talking with a counselor to be helpful?** ☐ **YES** ☐ **NO**
  If yes,
  ☐ In the Disaster not at all rarely sometimes often very often
  ☐ Continuing now not at all rarely sometimes often very often

Personal Experiences Disaster Survey (Page 6)

• Has your family have spent more time with others? ☐ **YES** ☐ **NO**

If yes,

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

• Have you received a lot of useful information about disaster-related stress? ☐ **YES** ☐ **NO**

If yes,

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

• Have you experienced a great deal of frustration trying to obtain government assistance? ☐ **YES** ☐ **NO**

If yes,

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

• Do you feel more distrustful of government? ☐ **YES** ☐ **NO**

If yes,

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

• Do you feel more distrustful in general? ☐ **YES** ☐ **NO**

If yes,

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

• Have you avoided talking with others about your disaster experiences? ☐ **YES** ☐ **NO**

If yes,

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

• Have you stopped attending church or temple regularly? ☐ **YES** ☐ **NO**

If yes,

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

• Have you discontinued a social or recreational activity because of loss of interest? ☐ **YES** ☐ **NO**

If yes,

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

Personal Experiences Disaster Survey (Page 7)

• **Have you received useful information about the effects of stress on children** ☐ **YES** ☐ **NO**

If yes

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

• **Do you spend more time with people?** ☐ **YES** ☐ **NO**

If yes

☐ In the Disaster	not at all	rarely	sometimes	often	very often
☐ Continuing now	not at all	rarely	sometimes	often	very often

Thank You For Completing this Disaster Survey

PCL-D

Your Name: _____ Date _____

Instructions: Below is a list of problems and complaints that people sometimes have in response to the stresses of disaster. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the disaster?	1	2	3	4	5
2. Repeated, disturbing dreams of a stressful experience from the disaster?	1	2	3	4	5
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of a stressful experience from the disaster?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the disaster?	1	2	3	4	5
6. Avoiding thinking about or talking about a stressful experience from the disaster or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they reminded you of a stressful experience from the disaster?	1	2	3	4	5
8. Trouble remembering important parts of a stressful experience from the disaster?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5

	Not at all	A little bit	Moderately	Quite a bit	Extremely
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being “super-alert” or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

Adapted with permission from the PCL-C for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane, National Center for PTSD - Behavioral Science Division

Referral Considerations: Current treatment methodologies, paradigms, and recommendations

For the survivors and emergency workers who continue to experience debilitating psychosocial impairments (e.g., post-traumatic stress disorder, other anxiety disorders, depression, or alcohol or substance use problems), referral for therapeutic care is essential in the recovery period. A prerequisite to making an appropriate referral for survivors or emergency workers in need of extended treatment is determining the knowledge and experience of potential providers. Providers to whom survivors and emergency workers are referred should be familiar with the longitudinal effects of stressors associated with disaster and with therapeutic interventions for the treatment of PTSD and other post-traumatic problems. The following section includes an overview of several empirically validated PTSD treatments and current treatment paradigms to help DMH clinicians make appropriate referrals. In addition, the overviews may be used to explain treatment options to clients in need of referral.

Clinicians should be aware, however, that the treatments described here may be unavailable in many or most communities affected by disaster. Instead, more general forms of counseling and psychotherapy may be provided. Nonetheless, the summaries which follow present the concepts and practices of some of the better-supported psychotherapies, and will help the referral agent in his or her selection and discussion with local treatment providers.

Cognitive-behavioral therapy (CBT) for PTSD, depression, and anxiety disorders

Barlow (1988); Chambless et al. (1996); Foa, Rothbaum & Molnar (1995); Follette, Ruzek & Abuey (in press); Resick & Schnicke (1993).

Generally speaking, CBT involves six phases delivered in a sequential fashion (Keane, 1995). Similar to all effective and ethically sound psychotherapies, the initial focus is on crisis management and the stabilization of the individual's family and work life. Stabilization involves a thorough psychosocial assessment of the individual's social and health history (including health risk behaviors and substance use), past and present psychological and somatic symptoms, current stressors and ways of coping, current social support network, vocational/educational status, values and beliefs, and personal resources (such as psychological hardiness, financial solvency, or personal resilience).

A second phase involves personalized education about the effects of stressors and trauma. Rather than teaching every person the same generic information about stress and trauma, psychoeducation is individualized to help each client understand the sources and nature of her or his unique stress reactions or post-traumatic symptoms in light of her or his unique experience of disaster stressors. Thus, for the individual who feels particularly hypervigilant and depressed, education might focus on how the normal reac-

tions of self-protectiveness and grief can become symptomatic problems.

Stress management intervention is a third phase in post-disaster CBT. Intensive teaching and practice of the systematic relaxation techniques described earlier in this *Guide* (e.g., guided imagery, breathing control, progressive muscle relaxation) can help a survivor or worker regain the capacity to achieve physical and psychological calm when experiencing stress or trauma-related anxiety. Learning ways to apply systematic problem solving to cope with, prevent, or manage stressors and personal/family difficulties (D'Zurilla & Goldfried, 1971) is also a useful adjunct in treating PTSD. Cognitive restructuring, which involves identifying and modifying beliefs or thoughts that intensify or prolong emotional, physical, or interpersonal distress, is a third component in stress management. As with trauma education, cognitive restructuring is most effective and acceptable for clients when done in an individualized manner that helps the client to recognize self-detracting and alternative self-enhancing beliefs or thoughts. For example, an emergency medical technician, who concludes that she is incompetent after having been unable to revive an asphyxiated disaster victim, can be helped to recognize that her judgment and beliefs are likely related to understandable feelings of grief and helplessness. It can be helpful to explain that had she been aware of such feelings in the midst of the rescue attempt, it would have seriously compromised her effectiveness. In this example, education could include how rescue workers, in general, often subconsciously repress such feelings during an operation. And, that rescue workers can benefit from becoming aware of the breadth of their emotional reactions after the operation to prevent repression from becoming debilitating. It also helps to explain that a rescue worker's feelings of grief and helplessness may further be understood as a reflection of their feelings of courage, commitment, and having previously saved the lives of others.

The fourth phase, "trauma focus" or "exposure," is widely associated with CBT. However, it is often mistaken as the beginning and end of CBT treatment for survivors. In actual practice, CBT requires a great deal of preparation (i.e., the three prior phases) before helping trauma survivors to review, or intentionally expose themselves to, the remembered experience of the disaster trauma. Similar to disaster debriefings, the re-examination of a survivor's trauma experience is carefully guided. However, in contrast to disaster debriefing, CBT begins the re-examination of the trauma experience *only* after the clinician and survivor are confident that the survivor is prepared to cope with or manage the troubling

post-traumatic symptoms (which often temporarily are exacerbated during the trauma focus phase of treatment). Focus begins with the survivor's factual recollection of the events. The therapist helps to magnify certain aspects of the account to begin discerning between the actual events and inferences the survivor has made about them. The recollection leads to an evocation of the survivor's key thoughts (both currently and at the time of the disaster) and emotions and reactions. The experiences, thoughts, and reactions can then be related directly to the survivor's current stress or post-traumatic symptoms and and how the "unfinished business" of the trauma experience results in symptoms that can be addressed by the process of re-examination.

The exposure process is repeated until the memories accessed and tolerated with less intense anxiety. If, after several sessions, the client experiences a sense of relief from having reviewed the trauma in tolerable "doses," the sense of fear, helplessness, and horror gradually shift to a healthy blend of feeling sad and acceptance of having been changed by the trauma. Many disaster survivors and rescue workers who experience serious psychological difficulties are able to emerge from trauma focus work with a clearer recollection and understanding of the disaster that gives coherence to their lives. In the most successful cases, there is a renewed sense of self-efficacy, greater involvement in supportive relationships, and increased hope toward the future.

The final two phases of CBT build upon the growing sense of closure derived from the re-examination of the disaster (and post-disaster) experience. The relapse prevention phase involves identifying potential ways in which the survivor or worker might experience an exacerbation of post-traumatic symptoms or associated impairment (i.e., a "relapse"), as well as planning specific steps the individual can take to anticipate, prevent, or manage such deterioration. Toward this end, CBT involves both routine and crisis-triggered "checkup" or "refresher" visits. Although CBT often can be accomplished in a fairly time-limited manner (e.g., 20-30 sessions), longer courses of treatment may be necessary for survivors who have prior trauma exposure or psychological difficulties. In addition, it is important to provide for continuing therapeutic assistance (typically on a much briefer basis) for even the most resilient and treatment-responsive survivor or rescue worker, because PTSD often involves periods of deterioration (e.g., at an anniversary of the disaster) that can be treated rapidly if identified early.

The stressors and trauma associated with disaster place a great

Interpersonal

Frank & Spanier (1995); Weissman & Markowitz (1995).

Dynamic

Brom et al., 1989; Marmar, Weiss & Pynoos (1995).

Emotion-focused therapy for PTSD, depression, or relational disorders

Greenberg & Safran (1989); Paivio & Greenberg (1995).

strain upon survivors' and workers' capacities to sustain the emotional integration, trust and intimacy, and the willingness to communicate and resolve conflicts that are essential to personal relationships. A sense of emotional numbness, detachment and aloneness, irritability and frustration, loss of the ability to enjoy activities and people, and distrust and hypervigilance are the hallmarks of PTSD. Interpersonal and dynamic therapies directly address these intrapersonal barriers to positive interpersonal adjustment and functioning.

Interpersonal psychotherapy (IPT) has been shown to be highly effective for the treatment and prevention of severe depression in extensive multisite research trials. IPT is delivered in three sequential phases but, like CBT, the phases often overlap and may be repeated several times over the course of each episode of treatment. The first phase corresponds to the crisis management and emotional stabilization phase of CBT, with an emphasis upon obtaining a diagnostic evaluation and psychiatric history that clarifies the client's specific presenting problems and recent changes in the client's relationships that appear to be associated with the primary psychiatric symptoms. In this opening phase a form of psychoeducation also takes place, in which the therapist identifies one or more interpersonal dilemmas that provide the client with a way to understand her or his emotional distress and psychiatric disturbance. For example, symptoms of depression may be linked to an issue of bereavement, to conflicts about roles and responsibilities in significant relationships, to transitions in relational roles (e.g., a child leaving home, a marriage or divorce), or to limitations in the individual's ability to communicate effectively or solve interpersonal problems.

The middle phase of IPT directly addresses core relational issues or problems by providing guidance as needed through bereavement, resuming sustaining personal and relational activities, developing new interests, activities, and relationships, resolving persistent relational conflicts, modifying and/or developing roles in key relationships, learning and utilizing social skills for relational communication and problem solving, and ending severely and persistently dysfunctional relationships. A "here-and-now" framework is utilized to ground the re-working of relational involvements in the immediate events of the client's current life. Thus, where CBT focuses on memories, thoughts, and emotions related to stressful or traumatic experiences, IPT emphasizes repairing the damage to personal relationships resulting from traumatization and post-traumatic psychosocial impairment — as well as enhancing healthy relationships. The final phase of IPT

involves a consolidation of the relational improvements achieved during treatment, relapse prevention, and a plan for future therapeutic maintenance.

Dynamic psychotherapies directly address the intense emotional conflicts that often become central to persistent post-traumatic psychosocial impairment. In dynamic psychotherapy, the client is helped with developing effective approaches to either resolving or managing unconscious beliefs and feelings resulting from a combination of problems stemming from formative relationships and recent stressors or traumas. Conflicts may involve unconscious emotions about betrayal, abandonment, rejection, violation, exploitation, seduction, coercion, entrapment, intimidation, humiliation, and withholding, among others. Dynamic psychotherapy proceeds in sequential stages that are determined by the client's receptivity and ability to recognize and take personal responsibility for these core intrapsychic and interpersonal dilemmas. The first phase of diagnostic and historical assessment is similar to IPT, except that in dynamic psychotherapy the therapist's formulation of the client's inner conflicts guides intervention.

The second phase of dynamic psychotherapy is an exploration of the client's current emotions and beliefs regarding self and relationships — not so much a review and restructuring of relational involvements (as in IPT) but rather an open-ended exploration of the client's spontaneous and unedited feelings and thoughts about what sort of person s/he is and wants to be, what gives life meaning and purpose, what emotional barriers s/he encounters and in dealing with other people, and what hopes and fears s/he has regarding a worthwhile and meaningful life. Therapist activities focus on guiding the client not toward any particular conclusion but toward a clearer and more sustained focus on emotionally "charged" concerns and conflicts that tend to be avoided. Where CBT emphasizes overcoming the avoidance of fearful traumatic memories, and IPT is directed toward overcoming the avoidance of or over-involvement in key relationships, dynamic psychotherapy focuses on overcoming the avoidance of one's own intense emotions and troubling thoughts or beliefs. Similarly to CBT and IPT (although with quite different specific therapist operations), the final phase of dynamic psychotherapy aims to prepare the client to handle emotional conflicts in the future without lapsing into a self-perpetuating vicious cycle of avoiding intense emotions (e.g., shame, guilt, despair) by ignoring troubling thoughts that unintentionally demean or disempower

oneself and key relationships.

Emotion-focused therapy (EFT) similarly centers around an improved awareness of emotions without dynamic psychotherapy's emphasis upon unconscious conflicts. Several streams of research suggest that unrecognized or unexpressed emotions are associated with impaired stress management and personal problem solving, and that experiencing moderate and tolerable levels of emotional arousal enhances these crucial self-maintenance operations in daily life and in psychotherapy. Therefore, the aim of EFT is to help clients achieve five types of change regarding how emotions are appraised and utilized. Emotions that clients are unaware of or that are dismissed as unimportant are brought to the fore. Individuals experiencing PTSD after a disaster often have difficulty recognizing or paying attention to any emotion other than irritation or anger, and may benefit from awareness of subtler emotions (e.g., grief, fear, love). Emotions are highlighted and even intentionally evoked to harness their motivational potential. For example, a client who is aware of being hypervigilant but unaware of the fear that motivates this symptom might be helped in describing the dangers that he is attempting to guard against and the way he feels when he imagines being unable to anticipate or prevent the occurrence of these dangers. Where CBT emphasizes evoking fear by re-examining trauma memories, and IPT and dynamic psychotherapy emphasize evoking a range of emotions by examining current or past relational or self-focused dilemmas, EFT strictly attends to emotions and incorporates any events, thoughts, or concerns that help the client recognize previously unidentified or discounted emotions.

The third type of change promoted by EFT is "emotional restructuring," which means bringing into sharp and immediate focus the personal and interpersonal dilemmas that evoke over looked emotions. Clients may be assisted in role-playing or imaginally playing out evocative scenarios, and in putting thoughts and other distractions aside to focus intently upon the feeling of emotion. When strong emotion is within the client's focus, techniques similar to those of CBT's cognitive restructuring are utilized to help the client re-examine and modify beliefs that maintain either distress (e.g., self-blame) or emotional numbness (e.g., hopelessness). This work leads into the fourth change operation underlying EFT, the identification of "hot cognitions," that is, thoughts or beliefs that trigger or sustain particularly strong emotions. These "hot cognitions" are examined as the products of personal experiences that the client can change by engaging in new and dif-

ferent life experiences (e.g., self-criticisms that change to self-confidence when a client chooses activities in which she can be successful and relationships that support rather than attack her self-esteem). The fifth change operation postulated by EFT is direct alteration of emotions, typically by planned therapeutic exposure to scenarios that evoke the emotion (similar to CBT or dynamic therapies), or re-working relational involvement (as in IPT). In these operations EFT differs from CBT, IPT, or dynamic therapies in its choice of primary emphasis, that is, emphasizing greater awareness of emotion to overcome traumatic fear, improve key relationships, and resolve inner emotional conflicts.

Pharmacotherapy for PTSD, depression, or anxiety disorders

Braun et al., (1990); DeMartino, Mollica & Wilk (1995); Friedman & Yehuda, (1998); van der Kolk et al. (1994).

Prescriptive medication may ameliorate persistent psychiatric symptoms and psychosocial impairment in the recovery and restoration periods following disaster, based on a similar approach to that described in the section on pharmacotherapy following a disaster. Antidepressant, anxiolytic, antiseizure, alpha and beta blocker, and antipsychotic medications, used judiciously and with careful monitoring by a qualified clinician, can reduce the severity of many symptoms experienced due to post-traumatic stress or psychiatric disorders. As such, psychotropic medications can enable clients to achieve sufficient fear and anger reduction, sleep restoration, mood stabilization, impulse control, and cognitive clarity to permit them to benefit more rapidly or fully than otherwise possible from psychotherapies. However, it is important that medication does not unintentionally exacerbate or prolong post-traumatic symptoms. No medication strategy has been developed and validated in double-blind research trials for the treatment of PTSD per se, let alone for PTSD resulting from exposure to disaster, so medication treatment must be designed and closely monitored on a very individual basis for each survivor.

Multisystemic family therapy for relational and child behavior problems

Henggler et al. (1996, 1995); Jacobson & Addis (1993); Pinsof & Wynne (1995).

Disaster can profoundly impact the families of survivors and rescue workers. Children, although often more resilient in the face of disaster than adults, may be psychologically unable to comprehend or integrate the shock of disaster. Seeking security and hope, children turn to parents who themselves may feel stunned, terrified, alone, or discouraged. Spouses are often separated in a disaster due to damage to the community's infrastructure. Moreover, in couples where one partner is a rescue worker, the rescue worker may be on assignment and inaccessible at the time when the couple/family would benefit from mutual support. The strongest emotional bonds may be ruptured or even severed by the shock of disaster, and recovery requires therapeutic assistance for the whole family.

Multisystemic family therapy (MFT) brings together a spousal pair or an entire multigenerational family to rebuild the "systems" that in the past sustained their relationships. The couple system is addressed by assisting primary partners to do a therapeutic debriefing of the disaster and the recovery experience conjointly. Elements of CBT (e.g., doing trauma focus work simultaneously as a couple, rather than alone as individuals; identifying and restructuring beliefs that intensify conflict between the partners), IPT (e.g., both members of the couple simultaneously resolving shared bereavement and changes in their roles in relation to each other), dynamic psychotherapy (e.g., identifying shared and divergent emotional conflicts), and EFT (e.g., gaining greater shared awareness of unrecognized emotions) are replicated in MFT. In addition, marital communication and problem solving skills, cyclical patterns of aggression or withdrawal, and sexual therapy may contribute to effective MFT.

MFT often involves children as well as the parental couple, and in blended or step-families may include several sets of children and parents. MFT is an extension of several models of systemic family therapy that was designed and has been field tested with families of adolescents experiencing conduct and substance use problems. However, the systemic therapies upon which MFT is based have proven effective in the treatment of family discord and dysfunction associated with a wide range of psychiatric and psychosocial problems with adults and children of all ages. In office or home therapeutic sessions, family-of-origin patterns may be explored by genogram, to clarify and reframe family rules and myths, and to identify functional and problematic family rules, rituals, and myths. Structural systemic interventions are used to restore generational boundaries and functional family coalitions and roles. Discordant, detached, or enmeshed marital or parental communication patterns are identified and experientially re-worked. All family members are helped to develop a shared explicit narrative of the disaster and post-disaster experience(s) that continue to be most troubling (as well as those that are positive sources of hope). Parents are assisted in developing rules and limits, incentives and logical consequences, and activities that instill an atmosphere of empathy and encouragement to assist their children with fears and anxieties or with impulsive or aggressive behavior problems. Beyond the office, MFT assists families in accessing and developing collaborative relationships with resources that often are either overlooked or viewed as adversaries by troubled families (e.g., schools, probation officers, child protective services social workers, financial counselors). The intent is to increase the

family's productive linkages with as many helpful "systems" outside the home as possible, including enhancing how the family actually interacts with potential resources.

Substance abuse education, treatment, and mutual support

Adams et al. (1996); Werner et al. (1996); Woody et al. (1991).

Previously undetected substance abuse (including alcohol) tends to be increasingly identified in the wake of disaster *when* potential "gatekeepers" (e.g., nurses, physicians, teachers, work supervisors) are (a) aware of the need to monitor these problems, (b) informed and equipped to recognize substance use problems, and (c) able to immediately access appropriate sources of help for identified individuals. The PTSD screening protocol developed by the National Center for PTSD for primary care settings, and adapted for DMH or medical/nursing providers to use in the wake of disaster (see Appendix C), includes a widely used and empirically validated 4-item screening instrument for alcohol use problems — the CAGE. A variety of similar instruments have been developed and validated for substance abuse as well as alcohol problems. However, no screening instrument is completely accurate, especially when attempting to identify persons at risk for substance use problems in a group — such as the ordinary members of a community hit by a disaster. An optimum screening is done by health care, social service, education, or employment personnel who have ongoing regular contact with disaster survivors, or by team leaders and members on disaster rescue teams — individuals who may observe changes in others' behavior that are a danger signal for potential substance abuse (e.g., erratic attendance, frequent accidents, concentration or memory problems, more frequent or less controlled alcohol consumption). With the exception of directly observed regular or excessive substance use, however, most such "red flags" may be due to a variety of other sources (e.g., anxiety or depression, PTSD, fatigue) and should be considered signs of substance abuse only after a thorough assessment.

The best and most readily available source of substance (or alcohol) abuse prevention and treatment is the informational materials on substance use problems produced and disseminated by health agencies, schools, religious organizations, and self-help support groups (e.g., AA, Rational Recovery). Both outpatient and inpatient drug and alcohol disorder treatment centers offer more intensive individual, group, and family education and counseling. Approaches emphasizing abstinence and frequent (e.g., daily or several days a week initially) contact with peer support persons are most widely available and strongly endorsed. Effective treatment approaches for substance or alcohol abuse typ-

ically utilize CBT (with a special focus on relapse prevention), family or interpersonal methods similar to MFT and IPT, and community-based support systems paralleling those developed for therapeutic maintenance of individuals with severe mental illness (see below).

Intensive community-based psychiatric case management for chronically mentally ill individuals

Drake et al. (1996).

The Madison model of intensive community-based psychiatric case management (CPCM) is designed to enable severely mentally ill individuals with, respectively, psychotic or borderline personality disorders, to maintain a stable adjustment in the community without incurring crises that require acute or long term psychiatric hospitalization. Chronically mentally ill individuals may suffer substantial deterioration or even complete decompensation as a result of the stress and trauma of a disaster. Thus, DMH clinicians are likely to encounter such an individual at any disaster relief or recovery site, especially at disaster shelters where marginal or homeless individuals are especially likely to come for assistance. These individuals can be disruptive or frightening for survivors or rescue workers, and may require acute psychiatric hospitalization. However, an immediate referral to an appropriate community-based program may prevent such crises, as well as reduce the strain that such individuals inadvertently place upon providers and community members seeking relief. Several elements from the CPCM model are potentially beneficial for the psychotic individual.

CPCM provides frequent regular contact with the client in situ, rather than only by sparsely scheduled visits to a medical center clinic or inpatient hospital treatment. Provider visits to home, work, school, employment office, or neighborhood milieus make possible clinical observation of the physical and social environments that make up a client's "real life." Clinician modeling and coaching of "real-time" social problem solving can help the client to incorporate symptom-management skills related to anticipating and coping with anniversary periods, symbolic trauma cues, or flareups of interpersonal conflict and hypervigilance. In addition, community visits enable the clinician to assess and monitor a client's skills.

CPCM focuses on individualized constructive life planning and fulfillment of responsibilities. An empathic therapeutic relationship and therapeutic narrative reconstruction of trauma and its sequelae are twin cornerstones of post-traumatic treatment, but they do not guarantee that the client has the requisite commitment, skills, and resources to actively take responsibility for her or his life. Post-traumatic avoidance, isolation, hypervigilance, and fear of loss of control become retraumatizing replications of the

original traumatic helplessness, terror, and hopelessness if not counterbalanced by present-day fulfillment of personally significant responsibilities. Thus, frequent in situ problem solving can be conceptualized as an essential in vivo component of post-traumatic therapy, not a side issue or lesser concern. Case management is an opportunity not just for practical problem solving and symptom management, but for exploration of the spiritual and moral dilemmas catalyzed by trauma and PTSD (e.g., loss of purpose or goals). Case management can help the survivor or disaster worker link with resources that can assist him or her in regaining a sense of purpose and productivity in day-to-day life (e.g., religious advisors, vocational counselors).

CPCM's emphasis upon development of a stable safe dwelling (e.g., transitional community residence) to reduce the severe strain of homelessness is consistent with the DMH goal of helping survivors re-establish residential security in the wake of disaster. Many psychotic individuals are homeless, but are invisible because of reluctance to become involved with social services — until disaster disrupts the person's limited resources and routine ways of maintaining a marginal existence. Others are sufficiently itinerant to have no real home, and find disaster shelters a welcome relief. Being homeless exposes the individual to high risk for additional traumatization (e.g., assault, robbery, accidents), to stressors that exacerbate trauma and psychosis (e.g., malnutrition, malevolent environments, social rejection), and to many direct and symbolic reminders of past traumas. Even the risk of homelessness—which may be a persistent concern for the chronically mentally ill with compromised work, financial, and family situations—is a debilitating stressor that can catalyze and intensify psychosis. Case management makes residential security and stability a primary focus as a preventive and therapeutic intervention in its own right.

Dialectical Behavior Therapy

Linehan et al. (1994).

Dialetical Behavior Therapy (DBT) was originally developed to prevent parasuicidal crises with the extremely emotionally unstable group of chronically impaired persons diagnosed with Borderline Personality Disorder. Such individuals tend to place frequent angry demands upon treatment providers, friends, and family members, often simultaneously accusing others of betraying their trust and neglecting their needs while criticizing and rejecting offers of help. When stressed, individuals diagnosed with Borderline Personality Disorder are prone to react with a combination of intrusive public expressions of rage, terror, and helplessness, which require extended intensive attention from skilled clinicians to calm and re-direct. Not even the best validated

forms of psychotherapy, including CBT or IPT, have shown any degree of effectiveness with Borderline Personality Disorder clients. Thus, typically these individuals receive frequent crisis hospitalizations and nonthreatening supportive therapy or long-term institutionalization — neither of which produce recovery or more than minimal quality of life.

DBT addresses the extreme emotional dysregulation commonly associated with Borderline Personality Disorder by providing several weekly sessions of individual and group treatment with the initial objective of having clients learn how to use reliable coping options instead of demanding crisis counseling or making suicide attempts when feeling overwhelmed by distress. In addition to helping clients become members of a mutual support group and partners with their counselors in preventing or managing emotional crises, a key element of DBT is providing a cohesive professional team to support the counselors' treatment monitoring and their effort to manage the personal strain associated with treating borderline personality-disordered clients. DBT services often can be accessed through local community mental health centers, which increasingly are adopting the DBT model to provide meaningful care for these otherwise extremely treatment refractory clients.

Primary healthcare education, screening, and treatment adherence interventions

Brown & Schulberg (1995); Fifer et al. (1994); Koss et al. (1990); Ford et al. (1996).

Most individuals experiencing psychological distress or behavioral and relational problems prefer to seek help only from their physician or primary care nursing specialist, or to not seek help at all. Such persons may accept a referral to a medical or nursing provider for physical health evaluation or treatment. The primary care paradigm developing within medicine and nursing offers a model for the delivery of health care services that can create a bridge from physical to mental health care. Primary care involves individualized case management by a primary provider with whom the patient has an on-going trusting relationship.

Primary care providers are well positioned to identify mental health problems and make referrals if adequately informed about efficient screening methods and risk factors. Although health care providers are legitimately concerned about escalating health-care utilization and costs, the detection of psychiatric comorbidity is not linked to overutilization or excessive costs. To the contrary, an "offset" of reduced health complaints and medical care utilization has been associated with psychiatric detection and specialized mental health care. Moreover, primary care patients tend to appreciate sensitive and tactful healthcare provider inquiries concerning their functional health status and well-being, and to

accept referrals for specialized psychosocial education or counseling for depression or stress. Many primary care providers serve as members of a multidisciplinary team that include mental health providers. The regular interchange between physical and mental health providers on such teams is an excellent basis for mutual education, as well as the development of truly integrative physical / mental health care plans.

Traumatic Reactivation: Helping survivors who have previously suffered PTSD

Estimated lifetime prevalence rates of PTSD (7.8%; Kessler et al. 1995) suggest that disaster mental health clinicians will see survivors who need to address traumatic reactivation (e.g., an earthquake victim who has successfully readjusted following an earlier sexual assault may begin to re-experience intrusive thoughts or nightmares about the assault). Moreover, clinicians have reported that acutely traumatized individuals with a history of previous traumatic experiences may be especially prone to experience adaptation problems (e.g., Hiley-Young, 1992; Lindemann, 1944; Solomon, et al. 1987; Solomon, et al. 1990). In these individuals, recent trauma serves to reactivate adjustment problems associated with the earlier trauma.

Differentiating between types of traumatic reactivation may serve as critical determinants of the type of interventions considered by disaster mental health clinicians. Hiley-Young (1992) and Solomon et al. (1987) propose similar reactivation models in which two categories of reactivated trauma are outlined. The first, referred to as ***uncomplicated reactivation***, is characterized by individuals who, after having been exposed to current disaster-related stimuli reminiscent of a previous traumatic experience, suffer a reactivation of traumatic symptoms (despite their having returned to a symptom-free level of functioning after the original trauma). The second category, called ***complicated reactivation***, is characterized by individuals who, after being exposed to the current disaster, suffer an exacerbation of residual PTSD from a previous trauma, with increased sensitivity and vulnerability to stressors and stimuli not directly related to either trauma.

Hiley-Young (1992) suggested that each type of reactivation requires distinct treatment. For uncomplicated reactivation (i.e., the survivor is intact characterologically, but unable to assimilate or tolerate feelings associated with the trauma and presents symptoms related to sensory reminders, intense affective states, intrusive thoughts, and psychic numbing), the major therapeutic task is to help the survivor consciously assimilate trauma-related memories, implications, and information. In cases of complicated reactivation (i.e., the survivor presents severe characterologic disturbance -- identity disturbance, feelings of alienation and mistrust, and extreme interpersonal difficulties), the therapeutic task is to help the survivor reconstitute a sense of self through a process of empathic engagement -- a process generally beyond the temporal scope of disaster mental health programs.

In cases of uncomplicated reactivation, a psychoeducational approach is appropriate. Active listening, giving didactic information about stress response syndromes, and facilitating the survivor's self-examination (with regard to the traumatic material

and its implications) are useful to assist the survivor's process of assimilating the trauma experience. Treatment may also include family therapy and efforts to mobilize the survivor's support system. The clinician seeks to understand the context of the reactivation in view of the survivor's psychosocial history including significant life events, significant stressors prior to the recent traumatic event, coping strategies successfully employed during adaptation to the original trauma, circumstances of the traumatic events, the survivor's behavioral, emotional, and cognitive response to the events, and the effects on the victim's family, job and social relationships. For a thorough and thoughtful clinical exposition of the steps in trauma-based therapy, see Keane (1995) and Young, Ruzek, and Ford (in press).

Though survivors with complicated reactivation of trauma are more appropriately referred to long-term psychodynamic-oriented treatment (without the constraint of the time-frame of disaster mental counseling programs), assessment will necessarily precede referral. In the course of assessment, characterologic disturbance may be "managed" by aid of regular appointment times, prompt beginning and ending of session times, and clear description of the scope of the "ad hoc" disaster mental health services. These structural elements may benefit the survivor by helping to establish the clinician as a stable "object" offering consistent support and care. For a description of treatment considerations of complicated reactivation, see Hiley-Young (1992).

Rituals and Commemorations

The terror and/or grief that disaster survivors feel can result in intense feelings of isolation, alienation, and stigmatization. Formal and informal rituals and commemorations allow the powerful emotions associated with these debilitating affects to be directed into activities that unify survivors with each other, their community, and in some instances, with the nation itself.

For survivors whose loved ones are killed by an act of terrorism, rituals are essential in the mourning process -- offering the hope that compassion, love, and goodness are larger than evil; that humanitarian values ultimately triumph over barbarism and the fearful aspects of reality. In a time of great loss, rituals can affirm survivors' identity and relatedness and strengthen them to act as a community to prevail over terror and adversity.

For survivors whose community has been ravaged, rituals can help reestablish the ruptured social equilibrium. For survivors whose lives are forever changed, rituals provide a sense of place in the universe, a place in the world, a place in the community and a place in families.

Understandably, rituals and commemorations are important in helping communities, families, and individuals recover from disaster. Mental health professionals can play a an important role in developing and/or consulting with community officials and survivors in planning commemorative activities.

The following comments about rituals are excerpted from the filming of Hope and Remembrance: Ritual and Recovery, a FEMA-funded training video available from the Center for Mental Health Services (Appendix B-Resources).

- *"It's never too late to have a reunion or a memorial service."*

  Molly Ward, 1937 New London Texas school explosion survivor and coordinator of 50th anniversary reunion.

- *"Typically there are two different kinds of anniversary activities. Activities are usually commemorative in nature, involving remembering the losses, particularly if there was a loss of life... remembering the people who have died, having a moment of silence, having prayer, and having community religious leaders from various denominations and religions to help in the commemoration. Activities are sometimes of a celebratory nature, when people are celebrating the fact that they've made it, not only through the original disaster but through all the aftermath and stress of the preceding year and the present."*

  Diane Myers, Disaster Consultant

- *"The most important people involved in the planning are the family members. It is an absolute disaster for a group of professionals who think they know what to do, to make plans without involving the victims themselves."*

  "The most important elements of a vigil or remembrance ceremony are making it meaningful for the victims. It's not a time for long speeches, it's not a time for political agendas."

  "It's almost an impossible task to accommodate the unique needs of every single victim. On the other hand, a lot of flexibility can be allowed. We will do everything we can possibly do to accommodate specific cultural needs."

  Janice Lord, Director
  Mothers Against Drunk Driving (MADD)

- *We know that even young children can rate their experience at funerals as very helpful under certain conditions. The main condition is that there is someone there to support them. It's not an issue of the child attending or not attending the funeral. It's having the child at the funeral with somebody who they know will be with them and who they perceive as supportive. We often have children help us to choose that person."*

  Robert Pynoos, UCLA Neuropsychiatric Institute

- *"Children can be involved in activities that are appropriate for their age. Younger children love to help and can help cook meals, help set a table or a room, or do simple things like put stamps on invitations. Adolescents can be involved with the direct planning of activities and can be asked to share a poem, thoughts, or heart felt memories."*

  "Rituals help provide a structure for children to experience their feelings and reactions as well as help them make sense of their feelings. Rituals also give children a sense of belonging."

  "Sometimes we forget that disaster workers are victims and deserve recognition for their effort and work. However, as a planner, one has to be careful with regard to recognition becoming excessive, as this can cause many workers discomfort. It is important that workers are acknowledged, but what seems more important to workers in some instances, is to help them find appropriate ways to share grieving with the community and their feelings about what has happened. "

  Bruce H. Young, Disaster Coordinator
  National Center for PTSD

SPECIAL POPULATIONS

Children

Like adults, children respond to trauma with symptoms of re-experiencing, emotional numbing, behavioral avoidance, and increased physiological arousal. By virtue of having less developed coping abilities, children must be considered among high-risk groups following a disaster. When traumatic death of a family member occurs, children are at increased risk for depression, stress reactions, and less individuation from the family (Bradach, 1995). Helping children recover from disaster is complicated by the developmental biopsychosocial issues related to age, gender, maturity, identity, parental and sibling relationships, coping capacities, etc. Intervention strategies must take into consideration these developmental issues.

Knowing a community's resources and the types of services available to children is essential to providing aid to child survivors and their families. A number of factors (e.g., magnitude of disaster, parental and school attitudes about mental health, and resource availability) determine whether and what type of "assessment" children may receive following disaster. During the first weeks after disaster, mental health workers generally have time for only quick and informal assessments (e.g., while staffing a shelter or disaster assistance center serving hundreds). The majority of interventions to help children adjust/recover are based on the a priori assumption that support, guidance, stress management strategies, information, normalization and validation are helpful to most children exposed to traumatic events, even in the absence of individual assessment.

Emergency Phase On-site Interventions with Children

At disaster sites immediately following the impact, initial mental health interventions with children are similar to those with adults—they are primarily pragmatic. When possible, gather information regarding each child's level of functioning from family members (assessment should not be limited to child's verbal report).

- **Protect:** Find ways to protect children from further harm and from further exposure to traumatic stimuli. If possible, create a "shelter" or safe haven for them, even if it is symbolic. The less traumatic stimuli children see, hear, smell, taste, or feel, the better off they will be. Protect children from onlookers and the media.
- **Direct:** Children may be stunned, in shock, or experiencing some degree of dissociation. When possible, direct ambulatory children away from the site of destruction, away from severely injured survivors, and away from continuing danger. Kind, but firm direction is needed.
- **Connect:** The children you encounter at the scene have just lost connection to the world that was familiar to them. A supportive, compassionate, and nonjudgmental verbal or nonverbal exchange between you and a child may help him or her to feel safe. However brief the exchange, or however temporary, such "relationships" are important to children. Try to present accurate information at regular intervals. Connect children:
  - ♦ To parents, relatives
  - ♦ To accurate information and appropriate resources
  - ♦ To where they will be able to receive additional support
- **Triage:** The majority of children experience normal stress reactions. However, some may require immediate crisis intervention to help manage intense feelings of panic or grief. Signs of panic are trembling, agitation, rambling speech, becoming mute, or erratic behavior. Signs of intense grief may be loud crying, rage, or catatonia. In such cases, attempt to quickly establish therapeutic rapport, ensure the child's safety and offer empathy. Stay with the child in acute distress or find someone to remain with him or her until initial stabilization occurs.

Emergency Phase Off-site Interventions with Children

There will be many places where child survivors who will be in need of psychological first aid are congregated. Such sites include:

Shelters and meal sites
Red Cross Service Centers
Medical Examiner's office
Emergency Operations Center (EOC)
Fire and Police departments
Disaster Applications Centers (DAC)
Hospitals and First Aid stations
Coroner's office
Schools and neighborhood community centers & churches

Wherever children survivors are

- **Protect:** As with on-site help, it is important to protect children from further harm and, as much as possible, from further exposure to traumatic stimuli. At this phase, the less traumatic children people see, hear, smell, taste, feel, the better. Protect survivors from onlookers and the media. Advise adults that television coverage with graphic detail of death and destruction should be off-limits to children.
- **Direct:** Again, kind but firm direction is needed in disasters. When possible, keep children away from severely injured survivors and those experiencing extreme emotional distress, to minimize fear and emotional contagion.
- **Connect:** Your support and compassion, whether expressed in words or in non-verbal ways, helps to reduce fear and reconnect the child to a sense of security. Connect children to parents or relatives. Try to present accurate information at regular intervals, and connect children to available appropriate resources. When possible, refer parents to additional sources of support for children.
- **Acute Care:** Those children who require immediate crisis intervention to help manage intense feelings of panic or grief can be helped by your presence. Stay with the child in acute distress or find someone else to remain with him/her until the feelings subside. Ensure the child's safety.
- **Other Environmental Considerations:** When possible, set aside a children's area supplied with mats, toys, stuffed animals, and art supplies (crayons, paints, paper, glue) staffed by mental health professionals who specialize in working with children.

- **Assessment:**

Assessment of the impact of a disaster and its related events on children will be influenced by the setting in which assessment takes place. Assessment can take place where parents and children congregate (e/g/, shelters, service centers, schools, churches, etc.). Informal assessment can involve inquiries of parents and/or other adults in contact with the child (e.g., shelter managers, teachers, other caregivers), and can include direct observation and conversations with the child. The most efficient way to informally determine if a child is at risk for severe reactions is asking about what traumatic stressors the child experienced.

Helpful questions to ask parents:
Where was your child when the disaster struck?
Do you know what he or she saw heard, smelled, felt?
Was your child injured in any way?
Did your child witness any injuries?
What did your child witness?

Since the disaster.....
How has your child been sleeping ?
Is your child become more quiet or socially withdrawn?
Is your child more restless?
Is your child expressing specific fears or concerns about safety?
Is your child asking to sleep in your bed?
Is your child been complaining more about stomach aches, sore throats, etc.?
Is your child wanting more attention than usual?
Is your child frequently angry?
Is your child resisting going to school or expressing an unwillingness to be separated from you?
Is your child expressing feelings of guilt or shame?
What changes have you noticed in your child's behavior?

Are you especially worried about your child's reactions?
Is there someone in your family who is able to stay with your child while you take care of getting things restored?

Caregivers (e.g., shelter managers, service center staff, teachers) may also be asked about their observations of the children they have responsibility for.

Helpful questions to ask caregivers:
Are there any children you have particular concerns about?
Have you noticed any children who are withdrawn?
Are there any children who are frequently fighting with other children?
Are there any children who seem to be re-enacting the disaster through play?
Are there any children who are complaining about being sick?
Are there any children who seem particularly sad?
Are there any children who seem particularly anxious?
Are there any children you would like me to talk with?

Thirty days after onset of the disaster, formal assessment protocols should be utilized in cases when Criterion A of the DSM-IV has been met.

Each answer (i.e., degree of severity) may be viewed in the context of the range of normal reactions to a disaster. Depending on various circumstances (e.g., setting, clinical assignment, time since onset of disaster, etc.), disaster mental health clinicians may deliver various interventions. These include providing information to parents (caregivers) about common reactions and intervention strategies, arranging time for more in-depth assessment, or providing referral to community disaster mental health or childrens services.

Early Post-impact Phase Preventive Intervention Strategies with Children[3]

Symptomatic Response/Issue	First Aid
Preschool through Grade 2	
1. Helplessness and passivity	1. Support, rest, comfort
2. Generalized fear	2. Protective shield
3. Cognitive confusion	3. Repeated clarifications
4. Difficulty identifying feelings	4. Emotional labels
5. Lack of verbalization	5. Help to verbalize
6. Reminders become magical	6. Demystification of reminders
7. Sleep disturbance	7. Telling parents / teachers
8. Anxious attachment	8. Consistent care taking
9. Regressive symptoms	9. Allow time-limited regression
10. Anxieties about death	10. Explanations of death
Grades 3-5	
1. Responsibility and guilt	1. Expression of imaginings
2. Reminders trigger fears	2. Identification of reminders
3. Traumatic play and retelling	3. Listening with understanding
4. Fear of feelings	4. Supported expression
5. Concentration / learning difficulties	5. Telling adults
6. Sleep disturbance	6. Help to understand
7. Safety concerns	7. Realistic information
8. Changes in behavior	8. Challenge to impulse control
9. Somatic complaints	9. Link between sensations and event
10. Monitoring parents' anxieties	10. Expression of concerns
11. Concern for others	11. Constructive activities
12. Disturbed by grief responses	12. Positive memories
Adolescents (Grades 6 and up)	
1. Detachment, shame, guilt	1. Discussion: Event, feelings, limitations
2. Self-consciousness	2. Adult nature of responses
3. Post-traumatic acting out	3 Link: Behavior and event
4. Life-threatening reenactment	4. Address: Impulse to recklessness
5. Abrupt shift in relationships	5. Understanding expectable strain
6. Desire for revenge	6. Address: Plans / consequences
7. Radical changes in attitude	7. Link: Changes and event
8. Premature entrance to adulthood	8. Postponing radical decisions

[3] Pynoos, R.S., & Nader, K. (1993).

Restabilization Phase School Interventions

The classroom can play an important role in helping children recover. Mental health clinicians can work with entire classrooms, individual students, parents, school officials, and teachers (Santa Cruz County Mental Health Services, Project COPE, 1990; Hiley-Young, Giles, & Cohen, 1991). Teachers can be quickly provided with brief training on how to conduct helpful classroom exercises and how to identify children in need of professional counseling (Alameda County Mental Health Services, Cypress Corridor Nine-Month Recovery Program, 1990). Generally speaking, classroom programs and follow-up require conscientious goal-setting. Programs must include well-designed "closure" to prevent intensification of children's fears or feelings of helplessness and vulnerability (see Pynoos & Nader, 1993). Several types of interventions have been used in classrooms though very few have been empirically validated. La Greca et al (1996) identify the following types of interventions:

Discussion of Disaster-Related Events

Various activities to promote verbal and / or non-verbal expression of the children's experience, questions, and concerns can be used, including drawing, storytelling, puppetry, and modified debriefing protocols.

Promotion of Positive Coping and Problem Solving Skills

Children are encouraged to develop coping and problem-solving skills and developmentally-appropriate methods for managing their anxieties.

Strengthening of Friendships and Peer Support

Often, disaster disrupts familial and social support. Helping children to develop supportive relationships with teachers and classmates through the use of small group activities (e.g., letter writing other survivors, posters, commemorative rituals) can serve this purpose.

Parents' "Drop-In" Group[5]

A valuable component to any intervention program offered to students is an informal drop-in meeting for parents. When possible, it should be held on the same day as the intervention. The meeting may be held when students are typically picked-up from school (thus requiring the school's cooperation with regard to a supervised play period), or the meeting may be held at night. The purpose of offering a drop-in group for parents is fivefold:

Five Purposes for a Parents' Drop-In Group

1. Provide information and rationale regarding the intervention.
2. Provide information regarding normal and prolonged stress response syndromes.
3. Provide a forum for parents to ask questions about their children.
4. Indirectly assess how parents are coping.
5. Provide referral information regarding on-going services, (e.g., disaster-related stress counseling, marital counseling, family counseling).

1. **Provide information and rationale regarding the intervention.**
   A. Review informed consent and confidentiality.
   B. Describe activities and their rationale (i.e. drawing, small group discussion).
   C. Prepare parents for possible reactions to interventions:
      1) Emotional reactions (the "unacceptable" meaning of the event may become more apparent to the child after the class).
      2) The child may experience more anger, fear, helplessness or guilt and have difficulty expressing these feelings directly; the child may regress; the child may express more dependency.
      3) These reactions are not to be feared by parents.
         a) the interventions do not create these feelings.
         b) techniques used are gentle, not confrontive.
         c) children who experience the above mentioned feelings are working to integrate these feelings.
         d) children's adaptation to disaster generally requires the integration of these feelings.
      4) To encourage this integration, encourage parents to ask their child about participation in the intervention, emphasizing the value of non-judgmental listening, validation of feelings, and the exploration of any fears the child may have had during or after the event. Encourage parents to reassure the child that they and other adults care about what happens to them.

[5] Adapted from Hiley-Young, B. (1991).

2. **Provide information regarding normal and prolonged stress response syndromes.**
   A. Emphasize that the main difference is one of degree rather than kind. Serious reactions are normal reactions taken to an extreme.
   B. Review common reactions for pre-schoolers, kindergartners, younger and older school children.
3. **Provide a forum for parents to ask questions about their children.**
   A. Be prepared to discuss specific children's participation, artwork, and your assessment.
      1) If a parent surprises you by expressing a *major* concern about either the child's artwork or behavior, it is appropriate to suggest that a future time be arranged so that you and the parent may have the opportunity to talk about the situation in depth.
      2) As a general rule, be descriptive rather than interpretive when discussing children's participation. Often, you can be the one to ask the parent – "What do you think it means?"
4. **Indirectly assess how parents are coping.**
   A. Determine if any parents are expressing signs of overwhelming stress.
      1) Remember the limits of the drop-in group (not a therapy group).
      2) Use generic educational examples to illustrate maladaptive coping styles (e.g., chronic irritability, increased substance use).
      3) Use examples that may suggest the existence of a stress syndrome in parents (e.g., diminished concentration, increased work absence, sleep disturbance or nightmares, appetite disturbance, loss of libido, unwanted thoughts about the disaster or related theme, depressed mood, withdrawal from social activities, hyperalertness, startle response, somatic complaints, etc.).
      4) Use appropriate opportunities to discuss stress management (e.g., rest, nutrition, relaxation, exercise, disaster preparedness, support systems, specific stress reduction techniques).
5. **Provide referral information regarding on-going services, (e.g., disaster-related stress counseling, marital counseling, family counseling).**

OLDER ADULTS

Older adults (65 years and older) also respond to trauma with symptoms of re-experiencing, emotional numbing, behavioral avoidance, and increased physiological arousal. However, stress reactions may also be indicated by a deterioration of functioning or a worsening of an already existent disease process. Consequently, older adults should be considered among the high-risk groups following a disaster.

The Disaster Preparedness Manual (U.S. Administration on Aging and Kansas Department on Aging, 1995) describes several factors associated with adaptation to disaster by the elderly:

- Elderly persons may experience particular reactions to trauma as a unique function of their stage in the life cycle. Faced with the potential losses of loved ones as well as their own abilities, older individuals can experience such feelings as increased insecurity even during normal, everyday living. After encountering the devastation wrought by a disaster, some older adults can find their natural feelings of insecurity and vulnerability magnified by the destructive, out-of-control nature of the disaster. They may react with feelings of increased hopelessness since they do not know if they will live long enough to rebuild their lives.
- The impact can also trigger memories of other traumas, thus adding to an increasing sense of being overwhelmed. Many of the anchors to the past such as their home of many years, photographs and treasured keepsakes - so much a part of their identity - are gone. Poor health and social isolation can only add to the ordeal.
- In the process of recovery, it is important for older people to reaffirm attachments and relationships. While they need to have access to familiar faces such as old friends and neighbors, often these supports no longer exist. If older people do not have significant others available, it is critical that contact be made via assertive outreach programs such as support groups. It is important that older Americans feel as though they still belong in the community.
- Older adults need a sense of control and predictability. Re-establishing routines and having a permanent place to live can help increase a sense of security, stability and control. Relocation and emergency sheltering may be unavoidable. However, retraumatization can be minimized by helping survivors remain as close to familiar surroundings as possible.

- Older individuals also need to restore feelings of confidence and self-worth. Self-worth can be enhanced by talking about past successes. Confidence may be nurtured via guidance in setting manageable goals. Self-direction is essential to one's sense of integrity.
- Because so much has been lost, older individuals also need to restore feelings of connectedness. Many will be left with little more than memories. Activities as simple as remembering and talking about their life can be a starting point that helps them reconnect with their unique perspective as a part of the history of mankind.

Factors Associated with Stress in Older Adults

Several factors common to older people may affect the stress level of an older adult *(*U.S. Administration on Aging and Kansas Department on Aging, *1995).*

Sensory limitations

Stevens & Dadrwala (1993); Wysocki & Gilber (1988).

Older person's sense of smell, touch, vision and hearing may be less acute than that of the general population. A hearing loss may cause an older person not to hear what is said in a noisy environment or a diminished sense of smell may mean that he or she is more apt to eat spoiled food. Because the process of deterioration progresses gradually, many elderly are unaware of the degree of loss.

Delayed response syndrome

Babins (1987); Cohen (1987); Cunningham (1987); Thompson (1987).

Older adults may not react to situations as quickly as younger adults. Disaster service centers will need to provide outreach and be kept open longer if older persons have not appeared.

Generational differences

Cole & McConnaha (1986); Rosenmayr (1985); Stahmer (1985); Zissok et al. (1993).

Older adults are not a homogenous group. Religious/social/cultural pluralism in the United States as well as the wide age range of older adults affect service delivery. What might be acceptable to an 80 year-old-person may not acceptable to a person 65 years of age.

Chronic illness and medication use

Kalayam et al. (1991); Katz et al. (1988); Oppegard, Hanson, & Morgan (1984); Rosen et al. (1993).

Higher percentages of older persons have arthritis. This may prevent an older person from standing in line. Medications may cause confusion in an older person or greater susceptibility to problems such as dehydration. These and other similar problems may increase the difficulties in obtaining assistance.

Literacy

Many older persons have lower educational levels than the general population. This may present difficulties in completion of applications or understanding directions.

Language and cultural barriers

Applegate et al. (1981).

Older persons may be limited in their command of the English language or may find their ability to understand instructions diminished by the stress situation. The resulting failure in communication could easily be further confused by the presence of authoritarian figures, such as police officers.

Mobility impairment or limitation

Older persons may not have the ability to use automobiles or have access to private or public transportation. This may limit the opportunity to go to disaster assistance centers, obtain goods or water, or relocate when necessary. Older persons may have physical impairments which limit mobility.

Welfare stigma

Many older persons will not use services that have the connotation of being on "welfare." Older persons often have to be convinced that disaster services are available as a government service that their taxes have purchased. Older persons need to know that their receipt of assistance will not keep another, more severely affected, person from receiving help.

Mental health stigma

Bumagin & Hirn (1990); Dubin & Frank (1992); Fink & Tasman (1992); Henry & McCallum (1986); Lundervold & Young (1992); Nelson & Brabaroi (1985); Peterson, Thornton & Birren (1986); Williams & Sturzl (1990).

Many elderly have negative attitudes and lack of knowledge about mental health services. Fear of stigma often stops the elderly from seeking mental health treatment. Education is an effective way to alter the perceived stigma of seeking or receiving mental health services. Linking mental health and physical health services together may also be an effective means to reduce perceived stigmatization. Initially focusing on pragmatic needs may help build the elderly's trust in a counseling program.

Loss of independence

Older persons may fear they will lose their independence if they ask for assistance. The fear of being placed in nursing home may be a barrier to accessing services.

Crime victimization

Stafford & Galle (1984).

"Con artists" target older persons, particularly after a disaster. Other targeting by criminals may also develop. These issues need to be addressed in shelters and in housing arrangements. Con artists often use home repair to victimize the elderly following a disaster. Education at disaster centers about these crimes may help prevent further victimization.

Unfamiliarity with bureaucracy

Salive et al. (1994).

Older persons often have not had any experience working through a bureaucratic system. This is especially true for older women who had a spouse who assumed responsibility for bureaucratic matters.

Transfer trauma (sudden and unexpected relocation)

Sudden and unexpected relocation can result in inadequate information about individual medical needs. In addition, the psychological tasks associated with adjusting to new surroundings and routines can lead to depression, increased irritability, serious illness and even death in the frail elderly.

Memory disorders

Environmental factors or chronic diseases may affect the ability of an older person to remember information or to act appropriately. An older person may not be able to remember disaster instructions. If interviewed, the elderly may have difficulty relating details in logical order due to age-related impairment of temporal and spatial memory.

Multiple loss effect

Thompson et al. (1984); Kekich & Young (1983); Lindgren et al. (1992); Pfeiffer (1987).

Many older persons have lost spouse, income, home, and physical capabilities. For some persons, these losses compound each other. Disasters sometimes provide a final blow making recovery particularly difficult for older persons. This may also be reflected in an inappropriate attachment to specific items of property.

Hyper/hypothermia vulnerability

Collins (1988); Kenney & Hodgson (1987); Thomas (1988); Watson (1993).

Older person are often much more susceptible to the effects of heat or cold. This become more critical in disasters when furnaces and air conditioners may be unavailable or unserviceable.